STATE OF CALIFORNIA
DEPARMENT OF INSURANCE
45 Fremont Street, 24th Floor
San Francisco, California 94105

FINAL STATEMENT OF REASONS

INDIVIDUAL DISABILITY POLICY LOSS RATIO REGULATIONS

File Number: RH06092236
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November 14, 2006

UPDATE OF INITIAL STATEMENT OF REASONS

On July 21, 2006, the Department of Insurance gave notice of the proposed adoption of amendments to California Code of Regulations ("CCR") Title 10, Chapter 5, Subchapter 2, Article 1.9 ("Standards for Determining Whether Benefits of an Individual Hospital, Medical or Surgical Policy Are Unreasonable In Relation to the Premium Charged Pursuant to Subdivision (c) of Section 10293"), sections 2222.10, 2222.11, 2222.12, 2222.13, 2222.14, 2222.15, 2222.16, 2222.17, and 2222.19. The notice stated that the proposed regulation would significantly increase the loss ratio requirement for individual hospital, medical or surgical policies, describe the actuarial method by which the loss ratio is to be calculated, provide that the new loss ratio will apply to new policies and to existing policies on rate revision, include mass-marketed policies, delete an obsolete preliminary screening procedure and an obsolete table of credibility factors, and make other, non-substantive, changes.

On October 25, 2006, after considering public comments on regarding the proposed regulation, the Department of Insurance made available for public inspection certain changes to the regulation text as initially proposed. The changes were sufficiently related to the rulemaking as originally noticed such that a reasonable member of the directly affected public could have determined from the original notice that these changes could have resulted. (Cal.Code Regs., tit. 1, §42.) Each substantive change is listed below, in the same order as those changes appear in the regulation.

Section 2222.11. Definitions:

Subdivision (a):

PURPOSE

This definitional subdivision was included as a part of the original regulation when it first became effective in 1962. The purpose of the amendment originally proposed for this section was to clarify the definition by harmonizing it with subsequent statutory enactments. For example, in 1981 Insurance Code section 10293 was amended to include mass-marketed policies within the category of policies covered by that section. The proposed amendment incorporates

the 1981 revision of section 10293 into the definition of "hospital, medical or surgical policy."

The originally proposed amendment also incorporated Insurance Code section 106(b), which was amended in 2001 to provide a definition of "health insurance.' The purpose of including the definition contained in Insurance Code section 106(b) was to clarify that, for the purposes of this regulation, the term "hospital, medical, or surgical policy" includes all policies covered by the definition in Insurance Code section 106(b).

In response to comments received in response to the proposed amendment, section 2222.11(a) has been revised to exclude from definition of "hospital, medical, or surgical policy" supplemental policies of individual health insurance that provide coverage for vision care expenses only, dental care expenses only, or short-term limited duration health insurance with coverage durations of 6 months or less. Comments expressed concern that such policies cover limited types of benefits, are not meant to substitute for comprehensive hospital, medical, or surgical policies, and are sold at a low premium. Because of the low premium, comments expressed concern that such policies could not sustain a 70% loss ratio. After considering these comments, the commissioner concluded that these policies should remain at the current 50% loss ratio. The definition of "hospital, medical, or surgical policy" in section 2222.11 was therefore changed to exclude these policies from the definition, so that they could be treated separately in the subsequent section, 2222.12, that discusses standards of reasonability.

NECESSITY AND RATIONALE

The commissioner has determined that these amendments to the regulation are reasonably necessary. The rationale for this determination is that (1) harmonizing the definition with Insurance Code section 106 eliminates potential ambiguities regarding terminology, and (2) explicitly incorporating mass-marketed policies, as provided for in the 1981 amendment to Insurance Code section 10293, ensures that the regulation will achieve the legislative purpose of requiring that mass-marketed policies, as well as individual policies, provide reasonable benefits in relation to the premium charged, and (3) exempting supplemental policies of individual health insurance that provide coverage for vision care expenses only, dental care expenses only, or short-term limited duration health insurance with coverage durations of 6 months or less permits separate treatment of these policies that the commissioner has determined is appropriate given their limited benefits, low premium, and supplemental nature.

New subdivision (g):

The originally proposed amendment included a definition of "lifetime anticipated loss ratio" in section 2222.11(g). The revision to the proposed amendment adds the article "the" in three locations for grammar and readability. This revision does not change the substance of the proposed amendment.

New subdivision (h):

PURPOSE:
Based on consideration of comments received, the commissioner has determined that disease management expenses should, if the insurer wishes to do so, be included in the calculation of whether the benefits provided under a policy are reasonable in relation to the premium paid. Disease management expenses involve services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications using guidelines and patient self-management strategies.

NECESSITY AND RATIONALE:
Disease management services, as described, can improve the health of insured, and can therefore reduce claims, and therefore the overall cost of health care. Because of these benefits, the commissioner has determined that disease management expenses may be calculated as part of the determination of reasonability. The revised subdivision (h) provides a definition of "disease management expenses," based on Health & Safety Code section 13990.901.

New subdivision (i):

PURPOSE
This new subdivision provides definition and method of calculation for a "lifetime anticipated disease management ratio." This definition parallels the definition and calculation method of "lifetime anticipated loss ratio" provided in subdivision "g," and uses the same accepted actuarial principles and calculation method used in the definition of "lifetime anticipated loss ratio." An actuarial lifetime anticipated calculation is used because such a calculation method provides the most accurate evaluation of the expenses over the lifetime span of an insurance product. The "lifetime anticipated disease management ratio" is defined separately from "lifetime anticipated loss ratio" because the disease management factor is used as a separate factor, at the option of the insurer, in the determination of compliance with the standards of reasonability provided in revised section 2222.12

NECESSITY AND RATIONALE

The rationale for the Commissioner's determination that this amendment is reasonably necessary is that the proposed change will describe the calculation methods with greater specificity using terms currently accepted by the actuarial profession so that all persons affected by the regulation will clearly understand the method by which the factors included in the determination of the standards of reasonability is to be calculated. An additional factor, the lifetime anticipated disease management ratio, in included in order to encourage the use of disease management services to improve patient outcomes, and thereby control costs.

AUTHORITY AND REFERENCE:

Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

Section 2222.12:

PURPOSE

The purpose of the proposed change to this section of the regulation is to ensure that hospital, medical or surgical policies return a reasonable benefit per premium dollar, as required by Insurance Code section 10293.

NECESSITY AND RATIONALE

The Commissioner has determined that the statutory objective of Insurance Code section 10293 is to assure that benefits provided under a policy are reasonable in relation to the premium charged, and that an amended loss ratio standard that reflects current market conditions would reasonably aid the statutory objective. Further, the Commissioner has determined that it is in the interest of insurers to have a market that includes the certainty of an adequate benefit standard with which all competitors in the market would have to comply. The Commissioner has also determined that a 50 percent loss ratio, developed over 40 years ago in a very different environment of medical cost and insurance coverage, is inadequate to assure sufficient benefits to the consumer without an unacceptable total premium cost. The Commissioner has therefore determined that amending the regulation to require a minimum loss ratio of 70 percent for hospital, medical, or surgical policies is reasonably necessary to carry out the purpose for which it is proposed.

In response to comments received during the public comment period regarding the effect that a 70 percent loss ratio might have on supplemental, non-comprehensive policies that provide coverage for limited types of health expenses (vision-only, dental-only, and short-term limited duration health insurance with coverage durations of 6 months or less), the Commissioner has determined that the loss ratio for such policies should remain at the current 50 percent level.

The rationale for the Commissioner's determination is set forth below:

1) Loss Ratio Regulation: Introduction

In the hospital, medical, or surgical insurance marketplace, large purchasers of group health insurance have expertise in judging the level of benefit. In contrast, small groups and individuals, particularly those who obtain coverage without the benefit of an agent, lack such expertise in judging benefits, and also lack market power in negotiating benefits. As a consequence, Insurance Code section 10293(a) recognizes that standards for the reasonableness

of benefits are necessary; these standards protect the individual consumer as they purchase this vital coverage in the insurance marketplace.

2) Achieved and designed loss ratios

Data obtained from the insurers with the largest share of the individual hospital, medical, or surgical insurance market in California revealed that, for one insurer, loss ratios for individual major medical policies between 2000 and 2004 ranged from 51 percent to 67 percent, with an average loss ratio of 57.6 percent over 5 years.[1] For another insurer, the loss ratios for individual hospital, medical, or surgical insurance policies ranged from 73 percent to 80 percent, with an average loss ratio of 74 percent; however, this latter insurer includes an "active lives" reserve in its calculations, and so its loss ratio calculations may appear larger than it would otherwise if calculated by the same method as the first insurer.[2]

In testimony at the June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation (file number RH06092236) conducted by the Insurance Commissioner regarding profitability of hospital, medical, or surgical insurance products, representatives of major issuers of California individual hospital, medical, or surgical insurance policies testified that the goal of their respective companies was to design insurance products that generate a loss ratio between 70 and 80 percent.[3] The proposed amended regulation changes the minimum loss ratio level at which the insurance policy will be deemed to be reasonable from 50 percent to 70 percent, thereby supporting the industry at a loss ratio level close to its current product design target level.

3) Costs and Savings in Health Care Market

As discussed extensively above, the health care marketplace has experienced dramatic changes since the existing regulation was enacted, including recent rapid increases in medical inflation. In addition to increases in medical costs, however, other changes in the health care market have resulted in savings. For example, advances in administrative technology over the past 40 years have substantially decreased the cost of data processing and storage, with resulting savings in the cost of policyholder enrollment and policy maintenance. The efficiencies gained through the use of technology make additional premium dollars available for benefits.

4) Loss Ratio Standards in Other States

In concluding that a 70 percent lifetime loss ratio for hospital, medical, or surgical policies is reasonably necessary to achieve the statutory purpose, the Commissioner has considered practices in other states. Some states do not regulate loss ratios. Other states have adopted model regulations promulgated by the National Association of Insurance Commissioners (NAIC), in which the minimum loss ratio varies from 50 to 60 percent, based on the level of renewability of the policy. However, even states that have adopted the NAIC approach have modified the required loss ratio; for example, South Dakota requires minimum loss ratios of from 70 to 60 percent, depending on renewability. Other states have loss ratio requirements of 65 percent (West Virginia, Minnesota, Maine, Florida, Colorado). Further, other states have loss

ratio requirements in excess of 70 percent. For example, New Jersey has a minimum loss ratio requirement of 75 percent, with an additional requirement of a premium refund if the minimum loss ratio is not achieved in a given calendar year. Also, the state of Washington requires a 74 percent loss ratio, less premium tax, for an effective minimum loss ratio of 72 percent.[4]

5) Conclusion Regarding Loss Ratio Level

In light of the practices of other states, and considering the impact of recent trends in medical cost and premium inflation on purchasers of individual hospital, medical, or surgical insurance policies in California and the stated product design goals of major insurers in the California market, the Commissioner has determined that a lifetime anticipated loss ratio of 70 percent more accurately reflects the current cost of health care and current market conditions. The current 50 percent loss ratio is so far below the market that it is of no utility; it does not provide protection to the benefit levels received by the consumer, nor does it provide a meaningful standard that protects responsible insurers who are providing reasonable benefits to policyholders during a time of rampant medical inflation. The current 50 percent loss ratio would only benefit outliers who design products that undercut the benefits provided by their competitors. The Commissioner has found that the current 50 percent loss ratio does not assure that California consumers will receive reasonable benefits from their insurance premiums. It is therefore reasonably necessary to amend the regulation to provide a loss ratio level that protects both consumers and insurers.

In response to comments received during the public comment period regarding the effect that a 70 percent loss ratio might have on the price and availability of supplemental, non-comprehensive policies that provide coverage for limited types of health expenses (vision-only, dental-only, and short-term limited duration health insurance with coverage durations of 6 months or less), the Commissioner has determined that the loss ratio for such policies should remain at the current 50 percent level.

5) Calculation of Loss Ratio

PURPOSE

The proposed amendment to this section also clarifies that the minimum loss ratio of 70 percent is calculated as a "lifetime anticipated" loss ratio. The purpose of this proposed amendment is to clarify the method by which the loss ratio is to be calculated.

NECESSITY AND RATIONALE

The rationale for the Commissioner's determination that this amendment is reasonably necessary to carry out this purpose is as follows: Existing regulation 2222.12 contains the following language regarding the method where by the loss ratio will be calculated: "an analysis of actual loss experience, giving due consideration to all factors relevant to the determination of how the past loss experience may be used to reasonably indicate the average loss experience which

should develop." This description of the method of "loss ratio" calculation does not use current actuarial terminology, and so may create the potential for different interpretations.

The proposed amendment to the regulation describes the method of calculation using current actuarial terminology, a "lifetime anticipated loss ratio." A lifetime anticipated loss ratio considers both the actual and anticipated experience over the anticipated lifetime of an insurance product in a way that takes into account random annual fluctuations in earnings and claims, as well as the fact that loss ratios during the early years of a policy are expected to be lower than loss ratios during the policy's later years. Using a lifetime anticipated loss ratio in the calculation of the reasonableness of benefits received incorporates both the historical and anticipated performance of a given policy, and so provides the fairest picture of the design of the insurance policy in terms of how well it will deliver benefits to the consumer. Use of a lifetime anticipated loss ratio therefore benefits insurers, in that it recognizes that loss ratios during the early years of a policy are typically lower, and therefore permits insurers to design their products to take this into account. By comparison, if the loss ratio analysis was based on past experience alone, insurers would be penalized for the low loss ratios experienced in the early years of a policy design. Similarly, consumers benefit from the use of a lifetime anticipated loss ratio, as it assures them that the low loss ratios in a policy's early years will be counterbalanced by benefits received during the later years of a policy. Use of this current actuarial terminology in describing the loss ratio calculation assures that all persons affected by the regulation will clearly understand the method by which the loss ratio is to be calculated.

Based on consideration of comments received, the commissioner has determined that disease management expenses should, if the insurer wishes to do so, be included in the calculation of whether the benefits provided under a policy are reasonable in relation to the premium paid. Disease management expenses involve services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications using guidelines and patient self-management strategies. Disease management services, as described, can improve the health of insured, and can therefore reduce claims, and therefore the overall cost of health care. Because of these benefits, the commissioner has determined that it is appropriate, at the option of the insurer, to incorporate disease management expenses in the determination of reasonability. In the revised regulation disease management expenses are included as factors in parallel to the loss ratio factors used, if the insurer wishes to include disease management expenses in determining compliance with the standard of reasonability. Thus, the sum of the lifetime anticipated loss ratio and the lifetime anticipated disease management ratio will meet the standard of reasonability if the sum is not less than 70 percent. Similarly, in the case of a rate revision to an existing policy, the sum of the anticipated loss ratio and the anticipated disease management for the future period for which the revised rates are computed will meet the standard of reasonability if the sum is not less than 70 percent.

6) Application to Certain Existing Policies

PURPOSE

The proposed amendment provides that the 70 percent loss ratio requirement applies to new policies delivered or issued on or after July 1, 2007. However, the proposed amendment also makes the 70 percent loss ratio requirement applicable to existing policies at the time a rate revision has been filed. The purpose of this amendment is to ensure that consumers who maintain existing policies receive the benefits of the change in the minimum loss ratio at the time of a rate revision.

The revised amended regulation clarifies, at new subsection 2222.12(b), that, for those existing policies delivered or issued for delivery prior to July 1, 2007, and not subject to any rate revision effective on or after July 1, 2007, the existing standard of reasonability of a lifetime anticipated loss ratio of 50% remains in force.

NECESSITY AND RATIONALE

The commissioner has determined that this amendment is reasonably necessary to carry out this purpose because the same economic forces impinging on future policyholders also affect current policyholders. The rationale for this determination is that many consumers tend to maintain coverage under individual hospital, medical, or surgical insurance policies for extended periods of time. Also, other consumers covered by individual hospital, medical, or surgical insurance policies may not be able to switch to other policies because changes in their health status render them unable to qualify for a replacement policy due to medical underwriting. These consumers are subject to the same increasing economic burden, and have the same vulnerabilities and lack of expertise and market power as new purchasers of individual hospital, medical, or surgical policies. However, although they require the benefits of an increased loss ratio, they will not receive these benefits if the proposed regulation applies only to new policies.

The proposed amendment, though, only applies to existing policies when a rate revision is filed. The rationale for this is that existing policies (for which no rate revision has been filed) may not be actuarially structured to meet the increased loss ratio requirements, and therefore it would be unduly burdensome to require that they do so. However, at the time of a rate revision, the insurer is presumably making adjustments to reflect increases in the costs of medical benefits. As the insurer is making premium adjustments to accommodate increased medical costs, the same adjustments can incorporate changes to bring the product into compliance with the new, increased loss ratio requirement. Because the premium is already being adjusted, making other adjustments to comply with an increased loss ratio requirement at the same time lowers administrative costs (as the insurer is already obtaining and considering premium and cost data for the product in evaluating its rates), and avoids the additional cost to the insurer that would otherwise ensue were the regulation to instead require that all existing policies immediately exhibit the increased loss ratio. Application of this regulation to new and existing policies is reasonably necessary to ensure, in an era of rapidly rising medical costs, that reasonable benefits are paid for each premium dollar.

The proposed amendment to this section requires that, upon the filing of a rate revision, the policy must demonstrate both a 70 percent lifetime loss ratio for the entire life of the product, as well as a 70 percent loss ratio for the period for which the amended rates are computed. The rationale for this approach is that it encourages insurers to request and implement rate increases in such a way that policyholders are not suddenly confronted with large increases. Also, the proposed amendment prevents companies with existing business who achieved loss ratios in excess of 70 percent due to actual losses prior to the effective date of the proposed regulation from attempting to recoup these losses through a subsequent rate increase that would depress the future anticipated loss ratio below 70 percent. This portion of the proposed regulation is reasonably necessary because large rate increases, or rate revisions that reduce anticipated loss ratios below 70 percent, would impair the ability of consumers to plan for their health costs, and would also result in the consumers sustaining premium costs that do not bear a reasonable relationship to the benefits received.

7) Vision-only, Dental-only, Short-term limited duration health policies

In response to comments received during the public comment period regarding the effect that a 70 percent loss ratio might have on the price and availability of supplemental, non-comprehensive policies that provide coverage for limited types of health expenses (vision-only, dental-only, and short-term limited duration health insurance with coverage durations of 6 months or less), the Commissioner has determined that the loss ratio for such policies should remain at the current 50 percent level.

8) Deleting Obsolete Provision

PURPOSE

The purpose of the proposed amendment to this section is to delete the provision of the 1962 regulation that provided for a 35 percent loss ratio for policies with an annual premium of less that $7.50 per person. There are no longer policies available at that premium rate, and so this provision is now surplus.

NECESSITY AND RATIONALE

The rationale for the Commissioner's determination that it is reasonably necessary to delete this provision is that the clarity of the regulation is improved by the removal of obsolete provisions.

8) Harmonizing Medicare Provision with Subsequent Statute

PURPOSE

The purpose of the proposed amendment to this section is to modify the reference to loss ratios for policies designed to supplement Medicare. This provision was added in 1978, and amended in 1983. On both occasions, a specific loss ratio amount was specified. In 2000, Insurance Code

section 10192.14 was enacted, specifying a loss ratio amount for policies designed to supplement Medicare. The proposed amendment of this section incorporates Insurance Code section 10192.14(a)(1)(A) by reference, rather than stating a loss ratio amount.

The revised amendment changes the letter designation of this subsection from 2222.12(b) to 2222.12(d) to reflect the addition of new subsections (b) [Existing policies without rate revision] and (c) [Vision-only, Dental-only, Short-term Medical].

NECESSITY AND RATIONALE

The rationale for the Commissioner's determination that it is reasonably necessary to amend this provision is that, should Insurance Code section 10192.14 be changed after the regulation is amended, the regulation will automatically incorporate any change in the statutory loss ratio amount without need for further revision. Further, in order to achieve further clarity and specificity, the proposed amendment makes reference to Insurance Code section 10192.4(l), which defines Medicare supplement policies. The revision of the amendment assigns a different letter designation for consistency.

9) Title of Section

The proposed amendment changed the title of the section from "Standards of Reasonability" to "Minimum Loss Ratio Standards." Because, after considering public comments, the Commissioner has now determined that insurers may, at their option, include disease management expenses as a further factor in determining reasonability, the revised regulation reverts the title of this section to the existing title, "Standards of Reasonability."

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

Section 2222.19. Filing Experience Data:

PURPOSE

The original amendment proposed changes to this section delete obsolete references to policies with annual premiums of $7.50 or less, and policies issued on the industrial debit basis, as such policies are no longer sold. Also, the phrase "pursuant to footnote (5) of the accident and health policy exhibit" was deleted, as the referenced exhibit no longer has a footnote 5.

Comments received during the public comment period expressed concern that, effective in 2007, the Accident and Health Experience Exhibit to the Annual Statement will no longer identify experience by policy form, and so would not provide the information needed to demonstrate compliance with the standard of reasonability. (The Exhibit and the Annual Statement are forms developed and revised by the National Association of Insurance Commissioners.) Accordingly, the revised regulation replaces the now-obsolete form reporting requirement with an updated and simplified report of loss ratios per policy form, supported by a certification by an actuary plus an optional schedule of disease management expenses if an insurer chooses to include such expenses in demonstrating compliance with the standard of reasonability.

NECESSITY AND RATIONALE

The purpose and rationale for the Commissioner's determination that it is reasonably necessary to amend this provision is that the clarity of the regulation is improved by discontinuing the use of an obsolete measurement method, and by instead substituting a replacement means by which compliance with Insurance Code section 10293 can be monitored.

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

UPDATED INFORMATIVE DIGEST

An Updated Informative Digest has been filed concurrently, as a separate document, with this Final Statement of Reasons.

UPDATE OF MATERIAL RELIED UPON

No material other than that presented in the initial statement of reasons has been relied upon by the Department of Insurance.

MANDATE ON LOCAL AGENCIES OR SCHOOL DISTRICTS

The Department has made a determination that adoption, amendment or repeal of the regulation does not impose a mandate on local agencies or school districts. The regulation has nothing to do with local agencies or school districts; it neither requires nor prohibits action on their part.

REASONABLE ALTERNATIVES TO THE REGULATIONS; IMPACT ON SMALL BUSINESS

The Commissioner has identified no reasonable alternatives to the presently proposed regulations, nor have any such alternatives otherwise been identified and brought to the attention of the Department of Insurance, that would be more effective in carrying out the purpose for which the amended regulations are proposed, or which would lessen any impact on small business, than the proposed regulation**.**

SUMMARY OF AND RESPONSE TO OBJECTIONS OR RECOMMENDATIONS

A verbatim recital of each written and oral comment, objection, and/or recommendation received during the public comment period and the response to each is attached hereto.

The following descriptive codes are used to describe the written comments:

"L" denotes "Letter." Each piece of correspondence bears a unique "L" number.
"C" denotes "comment." Each category of comment topic within each letter is identified. The numeric sequence for comments starts a "1" for each letter.
"T" denotes the topic category for each comment. The topics appear as headings in the following table. The topic category code number is marked on each comment on the letters themselves.
"P" denotes "page." All pages of all letters received are numbered in a single, consecutive numeric sequence from 1 to 98. Each page bears a unique page number.

To ease review, the comments have been grouped in the following descriptive categories:

1) Application to existing policies on rate revision
2) Definition of health insurance, 106(b) (2222.11)
3) Supplemental policies (vision-only, dental-only, short-term)
4) Definition of Lifetime Loss Ratio/ Including Disease Management Expenses
5) Demonstrating Compliance
6) Discretionary Exemption from 70% / qualified actuary
7) Loss Ratio Amount/NAIC model
8) Refund
9) Competitive Impacts
10) Agent in marketplace
11) Preliminary Screening Procedure
12) Other letters
13) Comments re: proposed revision to amended regulation: supplemental policies
14) Comments re: proposed revision to amended regulation: disease management
15) Comments re: proposed revision to amended regulation: statement of compliance

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
Topic 1: Application of new loss ratio requirement to existing policies at time of rate revision			
L1, C1, p. 1 (Ann Eowan, ACLHIC) *[see also L2, C1, p.1, Martin Mitchell, AHIP, which duplicates, with minor nonsubstantive editorial changes, comments in L1,C1]*	2222.10	**Section 2222.10: Applicability** The proposed regulations would increase the existing loss ratio standard from the current 50% to 70%, not only applicable to new policies sold after July 1, 2007, but also to policies approved and sold prior to the effective date of the regulations. This applies to the underlying policy as well as to rate revisions to existing policies. "Rate revisions" as defined by, and established by these proposed regulations, is a completely new standard of review that currently does not exist for policies approved before the effective date of these regulations. The proposed regulations therefore impose two new standards on existing policies that differ substantially from the rules under which those policies were initially approved.	**Response to comments regarding retroactivity, "takings," and contract clause:** The Commissioner respectfully rejects this comment. As has been clarified in the revised proposed regulation, existing policies retain their current minimum loss ratio requirements. It is only when a premium change is sought for an existing policy that the policy, already being actuarially adjusted for a new premium level, is required to also adjust to comply with an improved loss ratio level. Existing policies therefore only need to comply with an increased loss ratio if their rates are revised. The Commissioner disagrees that this represents a retroactive application. (Continued in next cell, immediately below.)
		Existing policies have been developed and priced based on companies' expectation that the remaining percentage of premium not spent on medical expenses would be available to pay for administrative expenses, commissions, taxes and target profits. The retroactive application of this regulation to existing individual disability insurance policy forms that had been approved and priced according to a different standard in essence constitutes a "taking" under the 5th Amendment of the	(Continued from cell immediately above.) The Commissioner has determined that the application of an increased loss ratio requirement to existing policies at the time of rate change does not represent an unconstitutional "taking," nor does it represent an unconstitutional interference with contract. The Department has reviewed cases submitted by a

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		Constitution of the United States, by the Department of 20% of the premium over the life of the product. Further, the retroactive application of the proposed change would impair an existing contract, which is unconstitutional under State law. Such retroactive application will impair both the underlying health insurance contract as well as contracts with agents for commission on that contract.	commenter (see below) in support of the argument that the regulation as proposed constitutes a "taking," and concluded that they are inapposite to the proposed regulation. In *Bowen v. Georgetown University Hospital*, (1988) 488 U.S. 204, 109 S.Ct. 468, the federal government promulgated regulations that required retroactive corrective adjustments to cost reimbursements to providers of Medicare services. In this case, a group of hospitals had been required to return over $2 million dollars in reimbursements, in contrast to the present regulation, which does not seek any return of past funds. The court in *Bowen* affirmed summary judgment for the respondents, but the analysis was focused on the authority granted by Medicare Act, an analysis which is not pertinent here. (Continued in next cell, immediately below.)
		While we concur that the Department has the authority to impose regulations on a prospective basis on policy forms approved after the effective date of the regulations, we question the Department's **authority** to retroactively change the rules under which products have been approved based on existing regulations.	(Continued from cell, immediately above.) In a second case, *Jersey Central Power & Light Company v. Federal Energy Regulatory Commission*, (1987) 98 P.U.R.4th 536, 810 F.2d 1168, the court considered a petition for review of order by the Federal Energy Regulatory Commission modifying an electric utility's proposed rate schedule, and requiring the utility to file reduced rates. The case particularly focused on the treatment in rate regulation of the utility's abandoned investment in a nuclear plant. In remanding the matter for further factual findings, the Court of Appeal focused primarily on due process considerations, and the adequacy of the regulator's hearing and factual basis. The court's

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
			"taking" analysis was based on consideration of the extent to which an investor in a public utility is guaranteed a return on investment; however, no findings of fact had been made on this issue. In a concurring opinion, there was discussion of when a taking occurs in the context of rate regulation. However, it is important to consider here that Insurance Code section 10293 does not regulate rates, nor is there an investment return guaranteed in a way comparable to the guarantees in public power utility regulation. Particularly in light of the fact that there was no holding in the case regarding a "taking" analysis, this case is of little analytic value here. (Continued in next cell, immediately below.)
		Thus, we would request that the regulations be amended as follows: 2210.10: This article is adopted pursuant to and in implementation of Section 10293(a) of the Insurance Code, ***and*** is applicable to individual ***health insurance*** ~~disability~~ policies ~~providing hospital, medical or surgical insurance coverages~~ as defined in Section 2222.11 herein, and mass-marketed policies as defined in Insurance Code Section 10293(c)(1) that are ~~either (1)~~ ***approved on or after July 1, 2007, and*** delivered or issued for delivery to any person in this State on or after ***that date.*** ~~July 1, 2007., or (2) delivered or issued for delivery to any person in this State on or after July 1, 1962 and subject to any rate revision effective after July 1, 2007,~~ *Rationale:* The changes above mirror those proposed by ACLHIC in Section 2222.11 (a) (see comments for that	(Continued from cell immediately above.) In *Duquesne Light Company v. Barasch* (1989), 98 P.U.R.4th 253, 109 S.Ct. 609, 488 U.S. 299; a Pennsylvania statute disallowing utilities' recovery of capital investments in discontinued nuclear power projects was held not to "take" the property of the utilities in violation of the takings clause of the Fifth Amendment. The final case provided by a commenter, *Massachusetts Automobile Rating and Accident Prevention Bureau v. Commissioner of Insurance*, (1980). 381 Mass. 592, 411 N.E.2d 762, reviewed the actions of the Massachusetts Commissioner of Insurance in setting automobile rates. In that matter, the court declined to reach the question of whether the Commissioner's allowance for profit resulted in

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		section). These changes would use the term "health insurance" as defined in Section 106 (b) of the Insurance Code, which is the term currently used to describe those products outlined in the "Informative Digest" and are the subject of the proposed regulations; namely, individual disability insurance policies that provide coverage for hospital, medical or surgical benefits. The proposed ACLHIC change would replace the arcane language used in 1962 with the term "health insurance" as instituted in statute in 2001. Secondly, the proposed change, coupled with the change proposed for Section 2222.12 (a), would make the regulation prospective with regards to the imposition of a new loss ratio standard for policy forms approved after that date, as well as any rate revisions to those policies, while ensuring that all policy forms meet the loss ratio standards under which they were approved.	confiscation, as the matter had been remanded for recomputation on other grounds. *Massachusetts Automobile* did not discuss a constitutional "taking" analysis, and therefore is not pertinent here. (See also *Board of Trustees v. Ceazan* (1983) 559 F. Supp. 1210, 1216: "A taking is more readily found 'when there interference with property can be characterized as a physical invasion by government..than when interference arises from some public program adjusting the benefits and burdens of economic life to promote the common good."). (Continued in next cell, immediately below.)
L1, C4, p.4 Ann Eowan, ACLHIC *[see also L2, 41, p.12* *Martin Mitchell, AHIP, which duplicates, with minor nonsubstantive editorial*		2. Consistent with our earlier comments regarding the retroactive application of the regulations to products approved under the current loss ratio standard, we would also request amendments to the newly added Subdivision (f) as follows: (f) "Rate Revision" means a change in premium rates that applies to *individual health insurance policies approved on or after July 1, 2007 and delivered or issued for delivery to any person in this State on or after that date.* ~~existing policies.~~	(Continued from cell immediately above.) The Department has considered cases pertinent to the concerns of the commenters regarding alleged interference with existing contracts. The Commissioner rejects the contention that the proposed regulation interferes with existing contracts, but also observes that, even assuming for argument only that private contracts are impaired by the regulation, the regulation nevertheless has a significant and legitimate public purpose, such as the remedying of a broad and general social problem. (see *20th Century Ins. Co. v. Superior Court* (2001) 90 Cal. App. 4th

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changes, comments in L1,C1]			1247, 1268-1269, *rev. denied.* Oct. 17, 2001, *cert. denied* April 29, 2002; The broad social problem here is the increasing difficulty that holders of individual insurance policies have in obtaining reasonable value for their premium dollar, so that adequate funds are available to pay for increasingly expensive health care costs. The regulation therefore is based on reasonable conditions of a character appropriate to a significant and legitimate public purpose (see *Ross v. City of Berkeley* (N.D. Cal., 1987) 655 F. Supp. 820, 827.) The Commissioner's authority for promulgating the proposed regulation is found in Insurance Code section 10293, which provides, in pertinent part, that: "The commissioner shall, from time to time as conditions warrant, after notice and hearing, promulgate such reasonable rules and regulations and amendments and additions thereto, as are necessary to establish the standard or standards by which the commissioner shall withdraw approval of any such policy." (Continued in next cell, immediately below.)
L1,C7, pp.6-7 Ann Eowan ACLHIC	2222.12	Further, Subdivision (a), as proposed to be added to Section 2222.12, would impose the new, higher loss ratio to all health insurance policies, including limited benefit products and those that have been approved and priced under the current 50% minimum loss ratio requirement. Thus, we would request that Subdivision (a) to be amended as follows:	(Continued from cell immediately above.) In response to this and other comments, the Commissioner has revised the proposed regulation to provide that certain supplemental policies will maintain the current 50% minimum loss ratio. (End of response re: retroactivity, "takings," and

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		(a) Benefits provided by ~~a hospital, medical or surgical~~ *an individual health insurance* policy shall be deemed to be reasonable in relation to the premiums if *under assumptions developed by a qualified actuary* (1) the lifetime anticipated loss ratio *for policies approved and marketed prior to July, 2007,* is not less than *the loss ratio approved for the form, and (2) the lifetime anticipated loss ratio for policies approved and marketed after July 1, 2007 is not less than* 70%, and ~~(2)~~ *(3)* in the case of a rate revision *applicable to a policy form approved after July 1, 2007,* the anticipated loss ratio over the future *anticipated lifetime* period for which the revised rates are computed to provide coverage is also not less than 70%.	contract clause.)
		Add a new Subdivision (b) as follows: *(b) Benefits provided by an individual limited benefit health insurance policy shall be deemed to be reasonable in relation to the premiums if under assumptions developed by a qualified actuary (1) the lifetime anticipated loss ratio for policies approved and marketed prior to July, 2007, is not less than the loss ratio approved for the form, and (2) the lifetime anticipated loss ratio for policies approved and marketed after July 1, 2007 comply with the minimum loss ratio standards for policies under the NAIC Model Guidelines for Filing of Rates for Individual Health Insurance Forms, Model 134.*	

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L1,C9, p. 6 Ann Eowan ACLHIC		The above requested changes to the regulations would accomplish the following necessary clarifications: 1. The definition of "health insurance" would be used **consistently**. 2. The language would **clarify** that qualified actuaries would be making the assumptions related to loss ratio requirements, as would be appropriate. 3. The applicability of the regulations would be prospective in nature, and apply the new loss ratio standard to those products approved after the regulations have taken effect, rather than retroactively make changes to products approved under different regulatory requirements (see comments on Section 2222.10). The proposed amendments would also ensure that products previously approved would continue to meet the loss ratio standards under which they were approved.	The Commissioner respectfully rejects this comment. The definition of "health insurance" provided in Insurance Code section 106(b) is incorporated within the definition of "hospital, medical, or surgical policies" in the regulation, and as such is used consistently throughout the regulation. The proposed regulation has been revised so that the statement of compliance required in section 2222.19 is to be provided by a qualified actuary. Please see comments under "Response to comments regarding retroactivity, "takings," and contract clause", above in this column, for response regarding commenter's assertions regarding alleged retroactivity.
		4. As indicated previously, there seems to be no compelling reason to change the minimum loss ratio standards as currently applicable to limited benefit plans. As also described, a 70% loss ratio far exceeds national standards for these products, and would essentially eliminate these product offerings from the market. However, should these regulations continue to apply to	In response to this and other comments, the Commissioner has revised the proposed regulation to provide that certain supplemental policies will maintain the current 50% minimum loss ratio.

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		limited benefit policies, we would strongly argue for the minimum loss ratio standards contained in the NAIC's Model Guideline 134, as cited in the proposed language on a prospective basis. The Model Guidelines take into account the differences associated with lower premium, or limited benefit policies, and are nationally recognized as actuarially sound.	
L 29, C1, p. 70 Ann Eowan, ACHLIC	2222.10	***[The initial comment period for the regulation closed 9/19/06. The following comment was received9/25/06, after the close of the comment period. The following was in response to a request from Department staff for citations to cases supporting the commenter's constitutional "taking" argument.]*** I want to reiterate our earlier point relating to the application of these regulations to products that have a low premium, such as dental or vision. The fixed costs on these products as a percentage of premium, by basic economics, are going to be substantially higher than many of the fixed costs relating to comprehensive hospital, medical, or surgery policies with much higher premiums. The takings arguments are very strong here and about the only way to bring one of the low cost dental policies plans into compliance would be to offer a much greater benefit package resulting in fixed costs being a lesser percentage of the total premium. The increase in cost for that increased benefit package would most likely price that dental product out of the market, particularly when there are other dental products available which are not regulated by the Commissioner. We could end up with far fewer people having dental coverage than we have today.	The department undertook legal research regarding the arguments pertaining to the "takings" clause, and interference with contract, raised by these comments. This research included a review of cases submitted by commenter Eowan subsequent to the closure of the comment period. Based on the legal research performed, the department concluded that the proposed amendment did not represent a "taking," nor did it represent an improper interference with contracts between insurers and others. Further, the department noted that the proposed regulation does not change the loss ratio requirement for existing policies; a higher loss ratio is only required if a rate increase is sought.

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		A few additional cases for you to read are the following: 1. *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 109 S.Ct. 468 (1988); 2. *Jersey Central Power & Light Company v. Federal Energy Regulatory Commission*, 98 P.U.R.4th 536, 810 F.2d 1168 (1987); 3. *Duquesne Light Company v. Barasch*, 98 P.U.R.4th 253, 109 S.Ct. 609, 488 U.S. 299 (1989); and 4. *Massachusetts Automobile Rating and Accident Prevention Bureau v. Commissioner of Insurance*, 381 Mass. 592, 411 N.E.2d 762 (1980).	
L 29, C1, p. 70 Ann Eowan, ACHLIC	2222.10	***[The initial comment period for the regulation closed 9/19/06. The following comment was received9/25/06, after the close of the comment period. The following was in response to a request from Department staff for citations to cases supporting the commenter's constitutional "taking" argument.]*** The following is a hypothetical analysis prepared by Bill Weller using a 60% loss ratio for major medical policies which results in an over $19 million taking. This is a sizable taking and would be exacerbated for products that assumed the current 50% loss ratio. The regulation will prohibit rate increases in the future until at least 70% of all past dollar have been paid as incurred claims. As an example assume that a company was operating at a 60% loss ratio and is dealing with a block of business written during the five years 1995-1999. also	The Commissioner has considered this comment and respectfully rejects it. As noted above, the Department's legal analysis is that the application of the 70% loss ratio to existing policies, when those policies choose to apply for a rate increase, does not constitute a "taking," nor does it represent an impermissible interference with contracts. The example provided by the commenter is misleading, as it assumes that the block of insurance business described in the example closes after 10 years. For an open block of insurance business, the existing policyholders, and those who purchased the policy in 2007, would receive the benefit of the 70% loss ratio.

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		assume that medical trend and premium increases are 8% per year. the results could be as follows: Year No of Lives Earned Premium Incurred Claims Loss Ratio 1995 2000 2,000,000 1,200,000 60% 1996 8000 8,640,000 5,184,000 60% 1997 13000 15,163,200 9,097,920 60% 1998 17000 21,415,104 12,849,062 60% 1999 19000 25,849,289 15,509,573 60% 2000 16150 23,729,647 14,237,788 60% 2001 13727 21,783,022 13,069,813 60% 2002 11668 19,996,899 11,998,139 60% 2003 9334 17,276,580 10,365,948 60% 2004 7000 13,993,030 8,395,818 60% 2005 4900 10,578,731 6,347,239 60% 2006 3430 7,997,520 4,798,512 60% 6 mon 2007 2870 3,477,162 2,086297 60% As of July 2007, a 70% loss ratio would be applied to this experience so that claims would need to 70% of future premiums plus 10% of the past premiums before any	

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		increases would be approved. since the past premiums are $191,900,000 and the current annual premium is $6,954,000, the regulation will require that the company exchange $19,190,000 or 2.76 times the current premium from their allowable for expenses and profits into incurred claims (benefits to the remaining policyholders which will create for them a loss ratio well above 70% - i.e. a very rich benefit for very few of the original insureds.).	
Testimony of Anne Eowan at September 19, 2006 public hearing pp. 24-25,26-27		First and foremost is the concern that we're raising that these regulations would affect existing p. 25 policy forms that have already been approved under a different set of regulations and different set of actuarial assumptions. That's a pretty serious concern that we do have with this and we'd like to discuss that with you further. .... First of all in terms of applicability, again we read these regulations as having the effect of applying all disability insurance policies that cover hospital, medical or surgical benefits, which would be both supplemental and comprehensive policies as you know it. When there is an existing policy form that goes and has a rate revision, which you do normally just for cost of living and a number of other things, medical inflation and not only because you are asking for an increase on your policies, then we see the 70 percent p.27 applying to the entire policy, not just to the rate revision. And so we see this as having a retrospective application and not a prospective one. And while we certainly agree that the Commissioner has the authority to adopt regulations on a prospective basis, we're very concerned that these would be going back and, in essence, unfairly impacting products that have just been approved, some of them under different actuarial assumptions.	Ms. Eowan's testimony at the hearing paralleled her comments in the above letter. The above responses to her comment are incorporated herein by reference.

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		We would, in essence, if you ever wanted to increase your prices for medical cost inflation or just general on that basis, you would be subject to a new loss ratio standard which would have a retroactive application. We see constitutional problems with that as well as just regulatory problems with that, so we would ask you that you look at our letter in that regard, and we provided language for all of our suggestions, hopefully that's helpful to you, that maybe put some words to some of our recommendations. And we've suggested some language that would make this prospective an applicability section. And we did provide some rationale for that.	
Testimony of William Weller, Omega Squared, at September 19, 2006 public hearing pp. 49-54		MR. WELLER: For the record, William Weller, W-E-L-L-E-R. I'm an actuarial consultant. My company is Omega Squared of Sedona, of Sedona, Arizona. And I'm here assisting ACLHIC. I think a lot of what we've been talking about is the allocation of your overall expenses. That's not a precise science. You know, you, even in life insurance or other types of businesses, you know what Page 50 your total expenses are, they change from year-to-year. They change for different reasons. Part of it is the amount of additional salaries that you pay to people. That tends to go up by Consumer Price Index type of thing, or somewhat similar to that. Some of it is related to the fact that you are trying to adjust to new structures. For example, over the last 20 to 25 years there has been significant additional cost to insurance companies that operate in the comprehensive pay dramatical market to try to control, to the extent they can, the increases in medical care cost that are being passed on, utilization controls, managed care contract, contractual arrangements, so that we're not reimbursing on the basis of charges. Which, as I'm sure you know, are in many cases not particularly relevant to actual cost. And then as Anne noted, there are things that come up that you have to spread, recognizing that they don't happen every year, but	In making determinations regarding the applicability of the proposed regulation to existing policies at the time of rate regulation, the Commissioner took into account the factors and issues set forth in Mr. Weller's testimony. Most of the factors discussed, however, are administrative costs (such as changing ICD codes) that, in the Commissioner's determination, are not appropriately included as a "benefit provided under the policy" under the meaning of Insurance Code section 10293. Because of these considerations, The Commissioner respectfully rejects this comment.

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		when they happen, they are fairly significant costs. A good example in the recent past is the HIPAA requirements and the requirements for electronic processing of every claim with the doctors. Well, getting the doctors to process claims on an electronic basis is not something that happened easily, and it Page 51 added significant expenses to insurance companies that were trying to operate with the doctors and to make sure that we receive all of the information that we're required to, that we protected it at the level that the government required us to, and that we provided the proper privacy notifications. That's a cost that you have initially to do a lot of changes, and then an ongoing cost thereafter. How you allocate that, you know, whether you allocate that as a percentage of premium, as partly fixed, partly a percentage, clearly part of it is related to the number of people, part of it is, you know, allocated however you would like it. We have coming down the pike in the very near future a complete change in the coding system for claims. The ICD codes are going to be changed. That's a event that you have to do a lot of changes in your programming and work to do. How do you allocate those costs? There is no clear standard approach to it. The typical approach, as Anne has noted, is that you have fixed and variable. Fixed costs tend to be spread by number of policies or number of insureds certificates, something like that. And variable costs are either spread by number of -- by a percentage of premiums or percentage of claims. For the most part, page 52 the claims administration costs are typically done on the basis of a percentage of claims. Whether all of that, you know, down to the economic true detail would necessarily be there is, you know, it's one of these things that at what point in time do you say this is a reasonable approximation of the actual. Does that answer your question, gentlemen? MR. SUMMERS: Do you have any, any numbers, any ideas as to estimates on the fixed versus the variable?	

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		MR. WELLER: Well, it clearly varies by the group market versus the individual. The fixed costs in an individual are all going to be per policy. The premium billing, the accounting, the reserving of a policy is, you know, if the policy costs -- you know, if the premium is 500, the billing costs and sending out the billing notice, receiving it back, paying the bank for processing it and everything is the same whether the premium is 500 or 5,000. As you move into the group insurance, you find that some of the expenses that a company has to do for their individual policies are done on an administrative basis by the group policyholder through their benefits department, or whatever, because that's cost effective for them. Page 55 And so if you look at two or five life group you'll find that nothing is done by the group policyholder. Everything has to be done by the insurance company. So your per policy expenses tend to be higher for small group. As it goes up, they tend to be much smaller, both because you are spreading it over a much larger premium, but also because a lot of the expenses are done by the benefits department. Are there rules? I don't think so. I think, you know, if you look at most companies and you look at what they are doing in terms of their claim adjustment expense, that they are holding it on their financial statement for future administrative costs to pay claims that have already been incurred, that's typically in the three to eight percent range. So claims adjustment expenses which typically are always considered variable, even though maybe a little bit of it isn't, are a fairly small portion. The commissions are a percentage of premium, premium tax. Overhead, maybe a number of companies may be allocated partly to per policies and partly as a percentage of premium. But it varies all over the lot. So your underwriting expenses are typically an issue. Issue expenses are per policy, underwriting may be 25 partly per policy, partly per premium. On the basis Page 54	

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		that as your premium goes up, you presumably have a greater potential risk, and therefore you would want to spend a little bit more time initially on underwriting to make sure that the person that you are accepting is consistent with your pricing for that risk.	
L2, C10, p. 15, Martin Mitchell, AHIP	2222.10	These requested changes will provide additional clarity to the proposed regulations, while protecting the fragile individual health insurance product market: ● The language would make clear the applicability of the regulations would be prospective in nature; the new loss ratio standard would apply only to those products approved after the regulations have taken effect, and would not make changes to products approved under *[sic]* different regulatory structure (see comments on Section 2222.10). The proposed amendments would continue to ensure that products approved pursuant to the provisions of the old regulation would be required to continue to meet the prior loss ratio standards.	For the reasons discussed extensively above in this topic section, and also discussed in the attached Final Statement of Reasons, the Commissioner has determined that the new loss ratio amount should apply to existing policies at rate revision, in order to satisfy the statutory mandate of Insurance Code section 10293, which requires that benefits provided under a policy be reasonable in relation to the premium charged. Given the inflation in health care costs, and the pressures these costs impose on purchasers of individual health policies, the Commissioner has determined that existing policyholders, at rate revision, should receive the same advantage of a reasonable loss ratio as would otherwise be enjoyed by a new policyholder.
L3, C2, p. 18 Steven Lindsay, CAHU		The regulations as proposed would apply the same standard to in force products as to well as new products. While we consider this a "taking" of assets which we believe is illegal on its face, we are even more troubled by the breaking of the agreement. We as agents have sold products to our clients under the rubric that they were going to get what was promised in the contract as signed and now the regulator who is mandated to protect them, is proposing to change the rules in the middle of the game and force carriers to, in all probability, take the products off the market and move the insured to products that meet the new	The Commissioner respectfully rejects this comment. Please see the extensive discussion of this topic under the heading *"Response to comments regarding retroactivity, 'takings,' and contract clause"*, above, at the top of this section.

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		standard. This will lead to mass chaos and market disruption that is totally uncalled for.	
L4,C3,p.23 Mark Sektnan, AIG	2222.12	In addition, under the Regulations the 70% loss ratio requirement is applicable to existing policies when rate revisions are filed. A company could not obtain a rate increase unless the expected *future* loss ratio is greater than 70%. Historically many products were priced to comply with the current requirements and obtain a 50% lifetime loss ratio. The proposal to significantly increase the loss ratio requirement for in force policies can severely impact a company's ability to operate profitably in the market as older products were developed and approved under the regulations in force at the time they were filed. Further, companies may choose to not renew coverages for policyholders that may have cancellable, optionally renewable or conditionally renewable provisions in their policies. In fact, the Department's Initial Statement of Reasons dated July 21, 2006 (page 9) indicates that some other states have adopted regulations in which the minimum loss ratio varies between 50% to 60% based on the level of renewability of the policy. The NAIC model regulations should be considered.	The Commissioner respectfully rejects this comment. With emphasis on administrative efficiencies, at the time of rate revision, existing policies can be adjusted to achieve the improved minimum loss ratio. The loss ratio requirement is a lifetime anticipated loss ratio, which takes both past and anticipated future performance into account. Significantly, most products are currently priced in excess of the current 50% loss ratio, and many are in excess of the proposed 70% loss ratio. The Commissioner has considered the NAIC model, but, after considering the circumstances of the California insurance market, and the impact of medical inflation on California consumers, determined that a 70% minimum loss ratio is reasonable in light of the discernable statutory objectives of Insurance Code section 10293.
L6, C4, p. 30 David Dellinger NAIFA-Calif.		Lastly, and perhaps most importantly, the proposed regulations would increase the existing loss ratio standard from the current 50% to 70%, not for new policies sold after July 1, 2007, but also to existing policies that were approved and sold prior to the effective date of the regulations. The retroactive application of this regulation	The Commissioner respectfully rejects this comment. Please see the extensive discussion of this topic under the heading *"Response to comments regarding retroactivity, 'takings,' and contract clause*", above, at the top of this section.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		to existing policies essentially constitutes a "taking" under the 5th Amendment of the Constitution of the United States, by the Department of 20% of the premium over the life of the product. Further, the retroactive application of the proposed change would impair an existing contract, which is unconstitutional under State law. Such retroactive application will impair both the underlying health insurance contract as well as contracts with agents for commission on that contract.	
L7, C5, p. 33 JP Wieske The Council for Affordable Health Insurance		Finally, if a revised rule is proposed and applies to any in- force business, the application date should be pushed back similarly, perhaps to January 1, 2008, in order for insurers to administer changes properly.	The Commissioner has considered this suggestion and respectfully rejects it. The Commissioner, in making this determination, has balanced the need to provide insurers with time to adjust to a new loss ratio with the need to fulfill the statutory requirement that consumers obtain a reasonable level of benefit for the premium dollars paid. Having weighed these consideration, the Commissioner has determined that a July, 2007 date for the new loss ratio to take effect both provides adequate notice, and provides consumers with prompt relief.
L7, C5, p. 33 JP Wieske The Council for Affordable Health Insurance	2222.10	s2222.10 Applicability This section applies the new loss ratio standards to all policies – including those written under the loss ratio of the previous version of the rule. The retrospective application of the rule to existing policies creates serious problems for insurance carriers. The policies were written and designed based on a specific loss ratio targets, and new loss ratio targets may force carriers to abandon these products. We strongly urge the new targets be applied on prospective basis only.	The Commissioner respectfully rejects this suggestion. The central issue regarding this regulation is the Commissioner's statutory obligation to ensure a reasonable relationship between benefits and premium, for the protection of the consumer of individual insurance policies. Applying the increased loss ratio only to new policy forms would not achieve this goal, as existing policy forms could still be sold that would not achieve the necessary reasonable loss ratio. Thus, many consumers would not receive the

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			benefit of the new loss ratio.
L9,C1,p. 43 Peggy Camerino, United American Insurance ↓	2222.10	We are most concerned with the applicability section of the proposed regulation. §2222.10 applies the new loss ratio standard to all policies – including those regulated under the previous version of the rule. We strongly urge you to reconsider and amend any loss ratio proposal to be applied only on a prospective basis. An increase to the lifetime loss ratio on in-force policies will negatively affect insurers in this market. In-force policies were written and designed based on a specific loss ratio target. Companies have generally already committed to commissions payable on in-force policies and have set up deferred acquisition costs (DAC) accounts for these policies.	The Commissioner respectfully rejects this comment. With emphasis on administrative efficiencies, at the time of rate revision, existing policies can be adjusted to achieve the improved minimum loss ratio. The loss ratio requirement is a lifetime anticipated loss ratio, which takes both past and anticipated future performance into account. Significantly, most products are currently priced in excess of the current 50% loss ratio, and many are in excess of the proposed 70% loss ratio. Further, fixed expenses such as agent commissions can still be accommodated, with savings obtained in other administrative efficiencies.
↓		We are unsure what an increase in the loss ratio to in-force policies accomplishes. In the *Policy Statement Overview* contained in the *Notice of Proposed Action* of July 21, 2006, the target for the relief offered by of the proposed revision is "purchasers of individual hospital, medical or surgical polices." The policy statement provides that purchasers lack expertise and market power, purchasers bear an increasing economic burden, and purchasers are a vulnerable population.	The Commissioner respectfully rejects this comment**.** The term "purchasers" used in the policy statement refers to consumers of health insurance in the broadest sense, including those continuing customers who, with regular premium payments, purchase health insurance on an ongoing basis, as well as those obtaining new coverage from a new insurer. The Department asserts that, notwithstanding the assistance provided by the services of a professional insurance agent, individual purchasers of health insurance lack the expertise and market power of large group purchasers.

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↓		To be consistent with the identified policy objectives, new or revised regulations should be drafted to impact purchasers of hospital, medical or surgical policies, not necessarily policyholders of these products. Policy objectives will not be accomplished by applying new or revised regulations to in-force policyholders.	The Commissioner respectfully rejects this comment. Please see the immediately preceding response; the distinction between "purchasers" and "policyholders" asserted by this commenter is not intended in the supporting documents supplied with this regulation. Instead, "purchasers" as used here encompasses both ongoing customers and new customers of an insurance company.
Topic 2: Definition of health insurance [Insurance Code section 106(b)]			
L1, C2, p. 2 Ann Eowan, ACLHIC *[see also L2, C2, p.11 Martin Mitchell, AHIP, which duplicates, with minor nonsubstantive editorial changes, comments in L1,C2]* ↓	2222.11	**Section 2222.11. Definitions.** 1. Subdivision (a) of Section 2222.11 uses two **duplicative** and confusing definitions of what is known as "health insurance." First, it maintains the old, arcane use of the term "hospital, medical or surgical policy" while adding and including the more modern and accurate term "health insurance," which is defined in Section 106 (b) of the Insurance Code. It creates great confusion as to how the old definition would contrast or differ with the term "health insurance" as defined under Section 106 (b) since several of the exemptions and descriptive terms are the same. For example, under Section 106 (b), disability income (or "loss of time" policies) and transportation ticket policies are already excluded along with other non-hospital, medical and surgical reimbursement-type policies. Yet, these types of products are partially exempted in the current language. Thus, the definitions conflict with and, in some instances, duplicate each other.	The Commissioner respectfully rejects this comment The definition in the revised regulation is not confusing. Instead, it provides clarity by updating the existing definition of "hospital, medical, or surgical policy" to clearly include all those types of insurance defined by section 106(b), and also excluding those types of policies that are excluded from the definition of 106(b) [such as, for example, disability income, hospital indemnity, or accident only insurance]. Thus, by incorporating 106(b) into the existing definition, the revised regulation makes clear that the updated definition includes all types of insurance encompassed within the definition of 106(b), as well as other types of insurance, such as mass-marketed policies.

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		The new definition of "health insurance," as added in the statutes in 2001, is more complete, more descriptive of today's products, and provides more **clarity** than the additive definition that currently is proposed in this subdivision. The definition in Insurance Code Section 106 (b) is as follows: **106. (b)** In statutes that become effective on or after January 1, 2002,the term "health insurance" for purposes of this code shall mean an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits. The term "health insurance" shall not include any of the following kinds of insurance: (1) Accidental death and accidental death and dismemberment. (2) Disability insurance, including hospital indemnity, accident only, and specified disease insurance that pays benefits on a fixed benefit, cash payment only basis. (3) Credit disability, as defined in subdivision (2) of Section 779.2. (4) Coverage issued as a supplement to liability insurance. (5) Disability income, as defined in subdivision (i) of Section 799.01. (6) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in	

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		any liability insurance policy or equivalent self-insurance. (7) Insurance arising out of a workers' compensation or similar law. (8) Long-term care. As you can see, the definition of "health insurance" in Section 106 (b) is not only more complete but subsumes the arcane descriptions in the current regulations.	
L2, C2, p.11 Martin Mitchell, AHIP	2222.11	Section 2222.11 (a) brings together two definitions for what is generally referred to today as health insurance. First, it continues to use the old term "hospital, medical, or surgical policy" and then adds language that that *[sic]* this term includes a policy of "health insurance," as defined in the Insurance Code at section 106(b). Use of these two terms creates confusion as to whether they are referring to the same types of policies and insurance business. Rather than continue using an outdated definition, we propose that the department provide clarity and solely use the legislature's new definition of "health insurance," as added in 2001, as a more accurate and comprehensive description of today's products.	The Commissioner respectfully rejects this comment The definition in the revised regulation is not confusing. Instead, it provides clarity by updating the existing definition of "hospital, medical, or surgical policy" to clearly include all those types of insurance defined by section 106(b), and also excluding those types of policies that are excluded from the definition of 106(b) [such as, for example, disability income, hospital indemnity, or accident only insurance]. Thus, by incorporating 106(b) into the existing definition, the revised regulation makes clear that the updated definition includes all types of insurance encompassed within the definition of 106(b), as well as other types of insurance, such as mass-marketed policies.
L1, C8, p.6 Ann Eowan,\ ACHLIC *[see also L2,*		Amend the proposed Subdivision (b) as follows: ~~(b)~~ *(c)* Benefits provided by a ~~hospital, medical or surgical~~ *health insurance* policy designed to supplement Medicare, as defined in subdivision (1) of Insurance Code Section 10192.4 must meet	The Commissioner respectfully rejects this comment The definition in the regulation is used consistently throughout, providing clarity by updating the existing definition of "hospital, medical, or surgical policy" to clearly include all those types of insurance defined by

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C7, p.15 *Martin Mitchell, AHIP, which duplicates, with minor nonsubstantive editorial changes, comments in L1,C8]*		the loss ratio standards established in Subdivision (a)(1)(A) of Section 10192.14 of the Insurance Code. The above requested changes to the regulations would accomplish the following necessary clarifications: 1. The definition of "health insurance" would be used **consistently**.	section 106(b), and also excluding those types of policies that are excluded from the definition of 106(b) [such as, for example, disability income, hospital indemnity, or accident only insurance].
L1,C10, p.7 Ann Eowan, ACHLIC	2222.12	5. Changes are proposed for Subdivision (b), which would now be (c), to make the use of the term "health insurance" consistent with regards to Medicare supplement insurance.	The Commissioner respectfully rejects this comment The definition in the regulation is used consistently throughout, providing clarity by updating the existing definition of "hospital, medical, or surgical policy" to clearly include all those types of insurance defined by section 106(b), and also excluding those types of policies that are excluded from the definition of 106(b) [such as, for example, disability income, hospital indemnity, or accident only insurance].
Testimony of Anne Eowan at September 19, 2006 public hearing pp. 28-32		In the definition section of the regulations, I would point to what I thought -- I think what you were page 28 attempting to do in these regulations is maybe make it clearer by citing the health insurance definitions in the code. As you are aware, ACLHIC was involved in that legislation that came up with the definition of health insurance. And we had attempted at that time to maybe come up with a more recent or less arcane definition of disability insurance. The concern we have with the first definition here is that it's additive and not substitutive. In essence, it keeps in	Ms. Eowan's testimony at the hearing parallels her comments in the above letter. The above responses to her comments are incorporated herein by reference.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		some of the arcane language that appears to apply, the same set of standards or at least describe the same type of policies that we're talking about in the definition of health insurance. But instead of striking this definition and instead putting in the health insurance definition to find in Section 106.B of the insurance code, it simply says it includes health insurance. And since many of the exemptions are duplicative to the health insurance code, I don't see that there is anything that you are adding here that isn't otherwise covered by the regulations by simply calling it health insurance. And I know you are also including mass-marketed policies. So what we're asking for is clarity. Because otherwise we're not quite sure what these other products are or what you are trying to get at that health p.29 insurance would not otherwise provide you as a definition. We think it's clearer, we spent some time and several thousands of discussions trying to come up with the definition everybody could agree on. So we would hope that that would be used throughout the regulations. I did in the letter put out the definition in 106.B. I know you are all familiar with it, but you will see that there is some duplication in terms of some of the exemptions such as transportation ticket policies and that sort of thing. What we're dealing with here is a 1962 regulation, and we've all so moved on since then but we're talking about much of the same product. We also are suggesting some clarifications by separating out what we're describing as health insurance. And I think I've just described that. We have new language for subdivision A, B and C, where we're separating out individual health insurance so that we're talking about what we're -- what I think we're all agreed is comprehensive insurance. Basically hospital, medical and surgical coverage rather than limited benefit products such as vision only and dental only. And I'm going to explain a little bit when we get to the competitive impacts, and perhaps before that, why we're	

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		so concerned about limited benefit policies. 0030 We actually, you know, there is no term for limited benefit policies in the statute or in regulation unless you include it in here. But this apparently is the term that the Department of Insurance is using when they approve these types of products. And the description that we have here under C is actually what the Department requires the carriers who sell these products to disclose in the outline of coverage. So we just use a term that the Department is already using thinking that that would be descriptive and certainly consistent with how you view limited benefit policies. If you are wondering how we got that. So we've sort of separated these out by threes. So that you can make it clear what it is we're talking about. And you'll notice that the list here, I've just defined limited benefit policy as a individual policy that is not marketed or sold as a substitute for comprehensive hospital, medical and expense insurance. That's exact language from the outline of coverage. It's not a health maintenance organization or major medical expense insurance. And I've included a laundry list of products that we generally, from statute, get exempted from say mandated benefit bills. Those of you who work with legislation probably are familiar with this long list that I end up having to Page 31 exempt from mandated benefit bills, because these are what we have called supplemental. And if you have any questions about any one of these, there is just a list so we can make it clear what it is we're talking about, but there may be other limited benefit policies that might be developed at some point. But clearly the Department seems to know what those products are. Any questions on the definition section in terms of the definition of health insurance?	

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
L2, C9, p.15 Martin Mitchell, AHIP	2222.11	These requested changes will provide additional clarity to the proposed regulations, while protecting the fragile individual health insurance product market: ● The regulation would utilize the legislature's more modern definition of "health insurance," thereby reducing unnecessary confusion over the application of the regulation.	The Commissioner respectfully rejects this comment The definition in the revised regulation is not confusing. Instead, it provides clarity by updating the existing definition of "hospital, medical, or surgical policy" to clearly include all those types of insurance defined by section 106(b), and also excluding those types of policies that are excluded from the definition of 106(b) [such as, for example, disability income, hospital indemnity, or accident only insurance]. Thus, by incorporating 106(b) into the existing definition, the revised regulation makes clear that the updated definition includes all types of insurance encompassed within the definition of 106(b), as well as other types of insurance, such as mass-marketed policies.
L7, C3, p. 32 JP Wieske, The Council for Affordable Health Insurance		Moreover, the definition of loss ratio is deficient, in that while it is very simple to use just paid claims in the numerator, consider the many related costs: cost containment measures to hold down provider payments, assessments for risk pool excess claims, claim management costs for expensive procedures, fraud prevention costs (payments for fraud are included), good grievance procedures, other claim department expenses, etc. Such claim- related expenses are often appropriately categorized under the term "losses," particularly among HMO's where a different business structure has capitation payments to providers covering many things. California should accordingly define loss ratio for health insurers to include claim-related expenses.	The Commissioner respectfully rejects this comment, because the Commissioner has determined that including the other administrative costs described would be inconsistent with the focus of Insurance Code section 10293 on "benefits provided" to the policyholders. Also, considering the different regulatory structures, comparisons with managed care products are of limited analytic value here.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
Topic 3: Supplemental policies (vision-only, dental-only, short-term), § 2222.11			
L1, C3 p. 3 Ann Eowan, ACLHIC *[see also L2, C3, p.12* *Martin Mitchell, AHIP, which duplicates, with minor nonsubstantive editorial changes, comments in L1,C3]* ↓	2222.11	Further, it is clear from the Informative Digest of these proposed regulations that the focus of the Department is on comprehensive, or what is otherwise known as "major medical" coverage. This is distinguished from smaller premium "limited benefit" coverage, such as vision-only, or dental-only coverage, which is designed to only cover some benefits and is not meant to substitute for comprehensive hospital, medical or surgical. Such limited benefit polices are very low premium, and thus imposing a 70% loss ratio standard would virtually price these Department of Insurance approved products out the marketplace. Thus, these carriers would no longer be able to provide these products and non-HMO limited benefit coverage would cease to be available to California consumers. This would be completely counter to the stated goals of these regulatory changes in the Informative Digest. We would recommend that the regulations specifically exempt these products from these new requirements, leaving them subject to the current regulations. Absent that, we are proposing the NAIC Model standards for these limited benefit policies, which would not allow limited benefit policy loss ratios to exceed 50%.	In response to this and other comments, the Commissioner has revised the proposed regulation to provide that certain supplemental policies will maintain the current 50% minimum loss ratio.
↓		Too this end, ACLHIC would propose striking all the existing language in Subdivision (a) of Section 2222.11, while adding a new Subdivision (b), and instead inserting the following:	In response to this and other comments, the Commissioner has revised the proposed regulation to provide that certain supplemental policies will maintain the current 50% minimum loss ratio.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		(a) The term "individual health insurance," as used in this article means an individual policy of health insurance as defined in Insurance Code Section 106 (b). "Individual health insurance," shall not include "limited benefit" health insurance policies as defined in Subdivision (c) off this section. *(b) The term "mass-marketed policy" as used in this article means a mass-marketed policy as described in Insurance Code Section 10293.* (c) *The term "limited benefit policy" as used in this article means an individual policy of health insurance that is not marketed or sold as a substitute for comprehensive hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance. Such limited benefit policies include, but are not limited to, vision-only, dental-only, short-term limited duration health insurance, Champus-supplement insurance, or hospital indemnity, hospital-only, accident-only, or specified disease disability insurance that does not pay benefits on a fixed benefit, cash payment only basis. For purposes of this article, Medicare supplement insurance shall be subject to Section 2222.12 (b) of these regulations.* *(Re-letter remaining section as appropriate).*	
L1,C6, pp5-6 Ann Eowan ACLHIC	2222.12	**Section 2222.12. Minimum Loss Ratio Standards** As earlier stated, ACLHIC would strongly recommend that the new loss ratio standards not apply to limited benefit products. However, if the Department chooses to include	In response to this and other comments, the Commissioner has revised the proposed regulation to provide that certain supplemental policies will maintain the current 50% minimum loss ratio.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
[see also L2, 61, p.13 Martin Mitchell, AHIP, which duplicates, with minor nonsubstantive editorial changes, comments in L1,C6] ↓		them in these regulations, we would strongly object to the same loss ratio requirements applying as they do to comprehensive products. In fact, the original regulations adopted in 1962, and proposed to be amended, recognize the difference between more comprehensive policies (described in 1962 as those priced at more than $7.50 per person in annual premium) and more limited benefit, smaller premium products (described as those premiums less than $7.50 per person in annual premium) by imposing a 35% minimum loss ratio on those smaller premium products as compared to the 50% imposed on more comprehensive products. That recognition is incorporated into the language the Department is proposing to strike at the beginning of Section 2222.12.	
↓		Thus, contrary to the reasoning in the Informative Digest (top of page 7) that this provision is "surplus" because there no longer are products priced at this level, we would argue strongly that the reason for the lower loss ratio for smaller premium products is directly related to the disparate impact that a higher loss ratio would have on limited benefit products. Premiums for dental insurance, for example, are a fraction of premiums for comprehensive, or "major medical," coverage. Consequently, a 70% loss ratio applied to small premium policies leaves a much smaller amount of premium (in dollar terms) to cover fixed administrative expenses. As mentioned before, applying the same loss ratio standard to limited benefit type policies would eliminate such products from the market (see "Competitive Impacts" later in this comment letter). In essence, companies would no longer be able to sell a viable product.	In response to this and other comments, the Commissioner has revised the proposed regulation to provide that certain supplemental policies will maintain the current 50% minimum loss ratio.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
Testimony of Anne Eowan at September 19, 2006 public hearing pp. 36-37		. But when it comes to limited benefit policies we definitely think that the existing regulation should either apply. We're not asking that no standard apply, we're just simply saying these new regulations should apply. Absent that, we would point to the NAIC model on that, because they were able to figure out somehow in their guidelines, 134, and you may be very familiar with that, what would be a limited benefit or what they call a low premium product. And so we're asking that they not be lumped in with comprehensive policies because it has serious competitive impacts. Not only in terms of really serving as a disincentive for anybody to get in that market, and thus increase new product design and new competition, but also the folks who are in it won't be able to be in it anymore. So we've asked for those changes. And I've -- we've given you some suggested language. In our language in subdivision A as it applies to what we would consider comprehensive policies, you'll notice that we've, you know, consistent with our position, have made it prospective. We use the term "health insurance" consistently throughout. But you'll Page 37 note that we made it clear that the policies that have been approved under a different standard, whatever standard they were approved under, they have to continue to meet those standards. We do have a new subdivision B, though, that talks about these limited benefit policies. And you'll see that we have the NAIC model in there. Again we would prefer that they just be exempted because I don't think that's who you are going after. So I have some rationale for that, but I would strongly ask that the Commissioner consider those changes that we're suggesting, particularly with the low premium. Because I don't think that's what you are trying to do is take these products off the market. In terms of filing experience data in point one nine –	Ms. Eowan's testimony at the hearing parallels her comments in the above letter. The above responses to her comments are incorporated herein by reference, with the following additional response: After considering the NAIC recommendations, and considering the practices and experiences of other states, the Commissioner determined that a the loss ratio set forth in the revised regulation would more accurately describe a reasonable relationship between benefits and premium, given the nature of the California insurance market and the needs of California consumers, for the reasons set forth in the Initial Statement of Reasons. Thus, the Commissioner respectfully rejects the suggestion offered by the commenter.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
L2, C11, p. 15 Martin Mitchell, AHIP	2222.11, 222.12	These requested changes will provide additional clarity to the proposed regulations, while protecting the fragile individual health insurance product market: ● The regulation would not apply to limited benefit or short duration policies. There seems to be no compelling reason to justify the change *[sic]* the current minimum loss ratio standards. A 70% loss ratio far exceeds national standards for these products, and will eliminate these product offerings from the market. ● In the alternative, if the department determines that these regulations should apply to limited benefit and duration policies, we would strongly advocate the adoption of minimum loss ratio standard for low premium policies meet *[sic]* those standard developed through the NAIC Model Guideline 34, as proposed be made on a prospective basis. The NAIC Model Guidelines incorporate the differences associated with lower premium or limited benefit policies and are nationally recognized as actuarially sound.	In response to this and other comments, the Commissioner has revised the proposed regulation to provide that certain supplemental policies will maintain the current 50% minimum loss ratio.
L4,T1, p.22 Mark Sektnan AIG	2222.11	Based on our understanding of the Regulations a number of our current accident, cancer, and mini-med products would fall under the products impacted by the Regulations. It is unclear whether the disability income policies and riders would fall under these Regulations.	The proposed regulation does not apply to those products excluded from the definition of Insurance Code section 106(b). Disability income insurance, or hospital indemnity, accident only, and specified disease insurance that pays benefits on a fixed benefit, cash payment only basis, therefore does not fall under the ambit of this proposed regulation.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
L5, C1, P. 25 Leanne Ripperger, PacifiCare	2222.11	Specifically, the suggested changes in the regulation apply to short term major medical insurance; a product that Golden Rule, our sister company, is very interested in offering in the near future. Because those policies are designed to fill the "gaps" in coverage when someone is between jobs or has recently graduated from college, short term policies are available for coverage periods of one to six months and are not renewable. Policies of this type are intended to be very affordable. Because of the limited duration of these products, acquisition costs must be recovered over this very short period of time. As a result, it would be very difficult for carriers, such as Golden Rule, to market these particular products with a 70% lifetime loss ratio. In light of the fact that many studies show a significant percentage of uninsured individuals are uninsured for a short period of time, we believe these products fill an important need in the California market. If the proposed regulation continues to apply to short-term plans, we believe it will discourage carriers from offering this type of plan which would leave a fair number of California residents that would otherwise purchase "gap" coverage, uninsured. To remedy this we suggest the Department consider including an exemption for short-term medical insurance written in coverage durations of six months or less. Alternatively, the Department could establish a 60% loss ratio standard for these types of plans. We would add that the same logic used for short-term major medical insurance would also apply to other limited benefit plans such as vision-only dental-only, hospital indemnity, hospital only, accident-only or specified disease insurance and similar solutions would apply.	In response to this and other comments, the Commissioner revised the proposed regulation so that the standard of reasonability for short-term limited duration health insurance will remain at the current 50% loss ratio.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
L7,C1 p. 31 JP Wieske, The Council for Affordable Health Insurance		Significant public policy questions have yet to be addressed by the proposed regulations. Will a seventy percent loss ratio make it difficult for carriers to ensure they have adequate reserves? What impact will the proposed loss ratio have on ancillary coverage like dental and vision? Is a seventy percent loss ratio appropriate for short term medical products that have very high administrative costs? Has the Commissioner considered whether all of these products will continue to be available in the California marketplace? Will health insurance carriers leave California as a result of the new regulations?	The Commissioner has considered this comment and the comments of others, and has accepted the comment by changing the proposed regulation to keep vision-only, dental-only, and short-term health policies at the current, 50%, minimum loss ratio level. Evaluation of case reserves are built in to the calculation of a lifetime anticipated loss ratio; therefore, objections based on reserving are not relevant to the analysis of this proposed regulation. Further, in the opinion of the Commissioner, insurance carriers will not leave the California market as a result of these regulation.
L7, C6, p. 33, JP Wieske, The Council for Affordable Health Insurance	2222.11	s2222.11 Definitions In this section the term health insurance is broadly defined to incorporate numerous new products. Typically, rate regulations are applied on a product-by–product basis rather than applying a single standard. We would urge you to limit the application of this section to traditional health insurance policies only, and to specifically exempt coverage like dental, short-tem medical, and vision policies. Also, amend the definition of loss ratio, whose numerator is the present value of future anticipated claims plus claim-related expenses as determined by a qualified actuary and denominator is the present value of corresponding future anticipated earned premiums.	The Commissioner has considered this comment and the comments of others, and has accepted the comment by changing the proposed regulation to keep vision-only, dental-only, and short-term health policies at the current, 50%, minimum loss ratio level. The Commissioner has considered, but respectfully rejects, the suggestion that claims-related expenses be a factor in the numerator of the loss ratio equation, as the Commissioner has determined that claims-related expenses are more appropriately considered to be administrative costs of the insurer and, further, that evaluating claims-related expenses as administrative

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			costs will encourage efficiency in claims handling. Further, the commissioner respectfully rejects the suggestion that the denominator of the equation be future anticipated earned premiums, as the Commissioner has determined that a lifetime anticipated ratio, involving both the accumulated value of past earned premiums and present value of future premium earning, provides a more accurate evaluation of the policy, as the past experience acts as a means by which the accuracy of the future actuarial assumptions can be assessed.
L8,C3, p.39-40 James Oatman, Assurant Health	2222.11	**Short Term Medical and Supplemental Products** In addition to the above concerns with major medical insurance, our concerns extend to supplemental and short-term medical products. In the Supplemental Products market, we anticipate the increased loss ratio could severely restrict the availability of products such as short term disability, accident–only, hospital indemnity, and specified disease products. These products fill important needs in the market and, due to their low premiums (often less than $40 per month), need the lower NAIC model loss ratios in order to provide adequate funds for marketing, underwriting and administration. Assurant Health is currently considering filing a variety of supplemental products in California; however, given a 70 percent minimum loss ratio we would be forced reconsider	In response to this and other comments, the Commissioner has revised the proposed regulation to provide that certain supplemental policies will maintain the current 50% minimum loss ratio.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		this business decision. Furthermore, Assurant Health fills a vital need in the California marketplace by offering Short Term Medical Insurance. This product is an important tool to ensure consumers are not exposed to financial ruin due to short-term gaps in coverage. Due to the limited duration of these plans, the acquisition costs are significant -- and a lower loss ratio is necessary to sustain this product line. In the event the minimum loss ratio increases to 70 percent, Assurant Health would be forced to make a difficult decision whether to continue marketing this product in California.	
↓		**Short Term Medical** Assurant Health markets a variety of major medical short term health insurance policies that individuals and families purchase to protect against catastrophic illness typically while in between employment opportunities or a recent graduate seeking initial employment. In 2005, more than 9,000 Californians purchased a short term policy from Assurant Health. Under the proposed loss ratio increase, Assurant Health would be forced to discontinue offering these products to California consumers because the change would not accommodate the acquisition costs associated with the policy on a short-term basis.	In response to this and other comments, the Commissioner has revised the proposed regulation to provide that certain supplemental policies will maintain the current 50% minimum loss ratio.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		Assurant Health recommends the following changes: 1. Exempt short term, limited duration policies as defined by California law from the proposed changes to the regulation; 2. Apply a unique loss ratio standard to short term, limited duration policies no greater than 50%.	
↓		**Supplemental Products** As mentioned, Assurant Health is considering entering this market in California. A 70% loss ratio standard would preclude this opportunity. Assurant Health recommends the following changes: 1. Exempt supplemental products from the proposed changes to the regulation; **2.** Apply a unique loss ratio standard to supplemental products consistent with the NAIC model law.	In response to this and other comments, the Commissioner has revised the proposed regulation to provide that certain supplemental policies will maintain the current 50% minimum loss ratio.
Topic 4: Definition of "lifetime" ratio, disease management expenses (2222.11(g))			

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
L1, C5, p.4 Ann Eowan, ACLHIC ↓	2222.11 (g)	3. Further, newly added Subdivision (g) adds a definition of "Lifetime anticipated loss ratio" that does not comport completely with the definition and intention stated on page 6 of the Informative Digest. On Page 6, the Informative Digest describes what is meant by a "lifetime anticipated" loss ratio, and states: "A 'lifetime anticipated loss ratio' considers both the actual and anticipated experience (including incurred claims, changes in reserves, taxes and commission, administrative expenses, and gross margin) over the anticipated lifetime of an insurance product in a way that takes into account random annual fluctuations in earnings and claims, as well as the fact that loss ratios during the early years of a policy are expected to be lower than loss ratios during the policy's later years." However, the actual definition for "lifetime anticipated loss ratio" includes only incurred claims in the experience of the policy. The definition included in the Informative Digest is not consistent in intent with the definition in the regulations. In some instances the Informative Digest more accurately describes the actuarial science, and in other cases it presents a lack of clarification as to those factors the department wishes to include in the definition. Thus, we would ask that the definition be clarified accordingly as follows: (g) "Lifetime anticipated loss ratio" means the ratio of (i) divided by (ii), where (i) is equal to the	The Commissioner respectfully rejects this comment. The inference drawn by the commenter from the statement in the initial informative digest was incorrect: the parenthetical statement merely listed factors that were included in benefits or non-benefit calculations in determining loss ratios. The Updated Informative Digest has been revised in response to this comment, removing the parenthetical phrase in question to avoid inadvertent misinterpretation.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		sum of accumulated value of past ~~incurred claims~~ *health benefit expenses* since the inception of *the* policy and the present value of future anticipated *health benefit expenses* ~~claims,~~ and (ii) is the sum of accumulated value of past earned premiums and the present value of future anticipated premium earnings.	
↓		Add a new Subdivision (h) as follows: *(h) "Health benefit expenses" means incurred claims; changes to reserves; commission and administrative expenses directly related to claims, such as paying claims, negotiating contracts with providers; and medical management, including prior authorization of services and ongoing management of complex cases.* *Rationale:* The above definition of "health benefit expenses" includes all those factors cited on page 6 with the exception of "gross margin" and "taxes" which are ordinarily not part of the calculation of lifetime anticipated loss ratio and clarifies those administrative expenses directly related to claims. This will provide needed **clarity** and actuarial **accuracy** to this definition.	Please see response immediately above. The Commissioner respectfully rejects this comment
Testimony of Anne Eowan at September 19, 2006 public hearing		MS. EOWAN: All right. Thanks. Moving through the regulations here, the next definition, this is a new definition that the regulations would add describing rate revisions, because prior to this the regulations did not apply a different standard or a new standard when you had rate revision. This bill would. And you'll notice that the only thing that we're suggesting here is that you make that prospective. Because	Ms. Eowan's testimony at the hearing parallels her comments in the above letter. The above responses to her comments are incorporated herein by reference.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
pp. 32-36		we do see that a rate revision on an existing policy is retroactive application. So that's the one change I've made there. Three in the letter is there is a new definition of lifetime anticipated loss ratio. And I would ask you to look back in the Informative Digest on page six. Because in the Informative Digest it attempts to describe what the Department means as a lifetime anticipated loss ratio, but they are different things than just incurred claims included in the definition on page six. And what we've done is we have tried to redefine or take a little bit of what's in the page on page six, what the Department was describing as what should be included in a lifetime anticipated loss ratio, and what was actually in the definition as it's in the Page 33 regulation. So what we're asking here is clarity. But we also think that there were some things included on page six that probably should be included. And you'll note that we have tried to separate it out by coming up with a term health benefit expenses. And these health benefit expenses, it's not just incurred claims. For example, I think Mr. Lindsay raised the issue that when you are doing case management or disease management where you are actually doing some medical management, but it has an administrative component, that that should be something that would be included in the administrative portion of a medical loss ratio. So we've included a few things here under health benefit expenses by defining administrative expenses directly related to claims. That's another thing that we've done. So there are some things that are just administrative expenses such as marketing that were not included in here. But there are some things that are included in the -- as a part of what is the medical management component provided contract, et cetera, that we did include in there. So we've taken kind of some things out of the page 34 description on page six that we didn't think was appropriate and have tried to expand just beyond the incurred claims.	

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		MR. ZAKER-SHAHRAK: I just have a question. Incurred claim, according to your definition, should include that, the administrative cost of paying the incurred claim? MS. EOWAN: Yes, yes, exactly. What we just need, it's not clear what you mean by incurred claims here. The Informative Digest comes up with a description of what would be included in that. So we're just asking for clarity here, and we've come up with some language we think does that. And we're asking for your consideration of it. All right. Those are our changes to the definition section. In terms of the minimum loss ratio standards, one of the things that we're raising, I know that there is some language that got stricken from the regulations that looked like it might be surplus as described in the Informative Digest. And that was in 1962 they decided to separate premiums out by whether or not you are paying more than $7.50 for your premium, and we'd all like to go back to those days. MS. HOGE: That was annual premium. Page 35 MS. EOWAN: Yeah, annual premium, or less than $7.50. Rather than surplus I think what they were attempting to do at that time is simply saying there should be two different standards associated with lower premium-type products and higher premium products. The way they dealt with it then is there was a 35 percent loss ratio that applied to those lower premium and a 50 percent loss ratio for the higher. We're suggesting something similar here. For the limited benefit policies, as we're describing them and defining them in the regulations, these are vision only and dental only. They have a very low premium. So 70 percent loss ratio, in essence, would make them unmarketable. In order for them to increase the prices enough to be able to have a 70 percent loss ratio when their administrative expenses are fixed, you would basically be taking indemnity type, vision only, dental only, the type of products I put in the definition of limited benefit off the market. And so we, rather than thinking it was surplus, I think they attempted to deal with it then. We would	

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		argue that the 70 percent loss ratio regulation should apply to the comprehensive policies that you are attempting to go after. We do have similar concerns Page 36 just in terms of what sort of unforeseen circumstances and consequences might come of that	
L6, C3, p. 29 David Dellinger, NAIFA-Calif.	2222.11	Another issue that is of great concern to NAIFA-California's members is that the proposed regulations do not address the key cost drivers of health care. Rather, the proposed regulations may limit the affordable insurance products available to consumers and create a disincentive for health insurers to invest in the activities that improve quality service for patients and reduced costs for purchasers.	The Commissioner respectfully rejects this comment. This regulation is designed to implement the mandate of Insurance Code section 10293, which requires a reasonable relationship between premiums and benefits. Because of this limited statutory scope, the regulation, of necessity, cannot address key cost drivers of health care. The revised regulation allows insurers to factor disease management expenses in demonstrating compliance, creating an incentive for such services. The Commissioner has determined that competitive forces will maintain the variety of available insurance products, and will provide incentives to insurers to maximize efficiency.
↓		Many administrative expenses are fixed in nature and by definition; health insurance products with lower premiums tend to have higher administrative expense ratios. These proposed regulations would penalize plans for developing products that are the most affordable for consumers. With the increasing costs of medical care, anything close to a cap may ultimately result in fewer options for those consumers that are the most sensitive to the costs of	The Commissioner respectfully rejects this comment. Insurance Code section 10293 focuses on benefits to policyholders. The affordability cannot be had at the expense of providing reasonable value to the insured. The Commissioner believes that competition will maintain the availability of a robust range of products.

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		premiums, which may lead to a higher uninsured population in California.	
↓		Additionally, the quality of health care does not result only from money spent in providers' offices or in hospitals. The funds spent by insurers on implementing programs that provide value to customers, such as the costs of reaching special populations and small businesses through agents with tailored products to meet their needs, are administrative costs that provide immense benefit to California businesses and individuals. Plans and insurers that emphasize management of care, unique programs tailored to such populations, and more customer service opportunities will inevitably have higher administrative costs. Limiting the funding for these administrative services will ultimately hinder the use and implementation of programs that provide the greatest benefit and efficiency to insureds.	The Commissioner respectfully rejects this comment. While recognizing that the activities described have value, the Commissioner has determined that including all such administrative costs as "benefits," or, alternatively, depressing loss ratios, would be inconsistent with the mandate of Insurance Code section 10293 that the insured received reasonable benefit.
L7, C4, p. 32 JP Wieske, The Council for Affordable Health Insurance ↓		A high minimum lifetime loss ratio is also unreasonable due to its one-sided nature and periodic review. If an actual annual loss ratio were higher than expected, the company is forced to swallow such past loss, since the future loss ratio must also meet the minimum. While if a past loss ratio were lower than expected, the company must make up the difference by increasing benefits or reducing premiums, etc., in order that the combination of past and future meets the minimum, as currently defined. Actuaries are quite unable to hit the minimum loss ratio exactly every period. A better approach is to set a minimum target loss ratio for a future period, and	The Commissioner respectfully rejects this comment, for the following reasons: A "lifetime" anticipated loss ratio provides a better view of the developing loss ratio that just using present value of "future" anticipated loss ratios. The reason is the following: Lifetime anticipated loss ratio takes into account both the realized historical loss ratios and present value of expected/anticipated future loss ratios. Therefore, it might be possible for a company to justify low realized historical loss ratios if

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		use the past experience only to analyze assumptions for the future. The company must still accept past losses; likewise, it may earn a gain if some annual loss ratio is low; however, any such good experience influences future rate changes. To maintain discipline, the rule should require certification by a qualified actuary that the anticipated future loss ratio meets the appropriate minimum. Nonetheless, if actual annual loss ratios remain too low, section 2222.17 would apply and the commissioner may withdraw authorization of the form.	it can show that over time the loss ratio will trend upward, and hence the company anticipates achieving a lifetime loss ratio that is above the minimum required ratio. Another reason for using lifetime loss ratio is that realized past loss ratios act as a reality check and a point of reference about what the company can present as expected future loss ratios to the regulator. In general, one expects loss ratios realized in future to be similar to the ones realized in the past. Also, if a block of business had realized low - lower than minimum required- ratios in the past, other things being equal, low historical realized loss ratios will be a reason for the company to file for lower rate increases in the future than otherwise would be the case. The company would need to realize higher than minimum loss ratios in the future in order to make up for the fact that it had realized lower than minimum loss ratios in the past. But if we had required the company only to have an anticipate "future" loss ratio above the minimum required amount, the company would never be required to make up for realized past low loss ratios, and therefore would not be required to return reasonable value to consumers.
↓		Similarly, consider a bell-shaped curve, the target loss ratio, and actual loss ratios. Insurance is used for random events, and the bell-shaped curve represents possible events under the law of large numbers. If actuarial assumptions are appropriate, the target loss ratio is the middle of the curve, but an actual loss ratio may be anywhere on the curve. If the experience is	(Please see preceding response, immediately above.)

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		credible, the curve is narrow, and an actual loss ratio should be close to the target loss ratio (though the curve has two long tails). However, if the experience is not credible, actual loss ratios may be distant from the target. Thus good judgment is needed in evaluating credibility and actual loss ratios, especially in view of the one-sided nature of a minimum condition.	
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 11-13		The other thing I think that we're afraid will happen is that the carriers have been, in the last three or four years, implementing a host of technological and specific illness, programs designed to reduce the cost of particular illnesses. And that all costs an enormous amount of money to do, to start up from scratch and put that all in place. And we think that if you, if you -- if we're in the process of reducing premiums, which is what we see happening in the marketplace, as medical inflation exceeds regular inflation, so cost of any given product goes up, we see folks migrating to price points in the premium range. And as they migrate, that means we have less money to put in place, medical, electronic medical records, or diabetic, programs for diabetics or programs for folks who have high blood pressure to help them control their own diseases and to reduce the overall cost burdens in the home marketplace. That we have less money to implement those programs. And we are, I think, just beginning to see the impacts of the disease management programs now. We're starting to have good numbers on those that are from, I guess from our perspective, very believable numbers, that they are actually having an impact and controlling the costs better than what we've seen in the past. That the sophistication level in the technologies that's now being applied are going to continue to increase their ability to monitor those diseases and to assist those unfortunate folks to manage their own illnesses or to manage those illnesses. So we're afraid that as the premiums go down the	In response to this and other comments, the proposed regulation has been revised to allow insurers to take disease management expenses into account.

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		amount of money that can be allocated to these programs which are not mandated, by the way, are things the carriers do in order to keep the insurance marketplace as it is today, or to keep a viable insurance marketplace.	
Topic 5: Demonstrating Compliance			
L1, C11, p.7 Ann Eowan ACLIC *[see also L2, C12, p.16* *Martin Mitchell, AHIP, which duplicates, with minor nonsubstantive editorial changes, comments in L1,C11]*	2222.19	**Section 2222.19. Filing Experience Data.** The existing language presumes that the filing of the Accident and Health Experience Exhibit (a prescribed supplement to the Annual Statement) will identify experience by policy form. Effective in 2007 there will be major changes to this Exhibit that will not provide the anticipated level of information. As such, we recommend that this section be stricken and instead changed to read as follows: *nless requested by the commissioner to provide more specific information on policy forms subject to the minimum loss ratio standards in Section 2222.12, a company shall annually provide a statement from a qualified actuary that lists the policy forms to which the standards complies and a statement that the minimum loss ratio standards have been met for the year.*	The Commissioner respectfully rejects this comment The Commissioner did, however, take this commenter's statement about the Accident and Health Experience Exhibit into consideration and, as a result, revised section 2222.19.

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Topic 6: Discretionary Exemption, Qualified Actuary			
L2, C8, p.15 Martin Mitchell, AHIP	2222.19	We request that a new Subdivision (d) be added as follows: *(c)* [sic] *The commissioner may, upon sufficient showing detailed by a qualified actuary, approve health insurance policies for sale in this state after July 1, 2007 with a lifetime anticipated loss ratio of less than 70% if the commissioner determines that such approval is in the best interest of purchasers of individual health insurance policies. Notwithstanding such showing by a qualified actuary, the decision whether or not to approve such filing shall be in the sole discretion of the commissioner.* These requested changes will provide additional clarity to the proposed regulations, while protecting the fragile individual health insurance product market: ● The language would clearly establish that qualified actuaries would be making the assumptions related to loss ratio requirements, as would be appropriate. ● New subdivision (d) would reserve to the commissioner's sole discretion, the authority to approve products or premiums that do not satisfy the 70% minimum loss ratio if determined to be in the best interest of consumers.	The revised proposed regulation provides that a statement of compliance, with supporting data, must be provided by a qualified actuary. The commenter's requested change regarding the Commissioner's discretion, is not necessary, as existing section 2222.12 permits the Commissioner to give "due consideration to all factors relevant" in determining compliance. Further, existing section 2222.16 provides, in pertinent part, that the Commissioner "shall consider all factors as are relevant to a determination as to whether the benefits are unreasonable in relation to the premium charged therefore."

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Topic 7: Loss Ratio Amount/NAIC Model			
L7,C2, p. 31 JP Wieske, The Council for Affordable Health Insurance ↓		We also believe it is important to note that a number of states – all of whom have strongly competitive markets and premium rates lower than national averages – have decided that rate regulation does not lead to lower premiums. In fact, CAHI has consistently found that rate regulation such as that being considered in California has led to higher overall rates, fewer consumer choices, and an increasing number of uninsureds.	The Commissioner respectfully rejects this comment, in part because the proposed regulation does not regulate rates, but rather the relationship between premiums and benefits, as required by Insurance Code section 10293. This system of regulation has been in place in California for over 40 years, over which time a thriving, competitive market has developed.
↓		While CAHI believes highly competitive markets are a regulator's best tool, if states do choose to regulate rates, it must be done in the correct way. The National Association of Insurance Commissioners (NAIC) has spent a good deal of time studying the issue of rate regulation. While not perfect, their solution sets the loss ratio based on the product – certainly a more appropriate approach than setting a single loss ratio for a variety of very disparate products. The NAIC loss ratio standard, as listed below, also does not cover a number of products encompassed by the proposed regulation.	After considering the NAIC recommendations, and considering the practices and experiences of other states, the Commissioner determined that a 70% loss ratio would more accurately describe a reasonable relationship between benefits and premium, given the nature of the California insurance market and the needs of California consumers, for the reasons set forth in the Initial Statement of Reasons. Thus, the Commissioner respectfully rejects the suggestion offered by the commenter.
↓		Medical Expense Optionally Renewable 60% Medical Expense Conditionally Renewable 55% Medical Expense Guaranteed Renewable 55% Medical Expense Non-Cancellable 50% Loss of Income and Other Optionally Renewable 60% Loss of Income and Other Conditionally Renewable 55% Loss of Income and Other Guaranteed Renewable 50%	(Please see the response immediately above.)

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		Loss of Income and Other Non-Cancellable 45%	
↓		California's competitive market has already resulted in many insurance products having loss ratios that exceed 50%. However, increasing the minimum loss ratio to 70% is excessive and unnecessary. The proposed 70% minimum loss ratio does nothing to reflect the appropriate distribution, administrative and management costs associated with the individual market. Neither standard deals with the myriad of differences required for a variety of plans encompassed by this rule including short-term plans, limited scope plans, and others.	The Commissioner respectfully rejects this comment, because the fact that the competitive market has resulted in insurers achieving lifetime anticipated loss ratios in excess of 70% shows that this level of benefit can be achieved while maintaining distribution and administration. The proposed loss ratio level supports those plans that provide this reasonable level of benefit to their policy holders.
↓		High minimum loss ratios do little except decrease consumer choice and lead to a market dominated by a very few carriers. Kentucky, New Jersey, and Washington have all experimented with loss ratios at 70% or above, and these loss ratios have led to a poor market in Kentucky, a disaster in New Jersey, and no individual insurance policies available in some regions in Washington. Excessively high minimum loss ratios cannot appropriately reflect substantial health insurer costs like premium taxes, managed care expenses, administrative costs (especially for prompt payment of claims), contributions to surplus to maintain solvency, marketing, timely claims payment and acquisition costs. Forcing insurers to operate at a loss is a clear recipe for disaster.	The Commissioner respectfully rejects this comment, in part because the fact that New Jersey, for example, is a guaranteed-issue market, which introduces factors regarding availability not present in the California individual market. Further, the Commissioner has determined that an increased minimum loss ratio requirement, while providing improved return of benefit to policyholders, also encourage administrative innovation. The fact that some major insurers in the California individual market already have lifetime anticipated loss ratios in excess of 70% demonstrates this. The comment also mentions managed care expenses, which are not found in products under the jurisdiction of the Department (instead, such products are regulated by the Department of Managed Health

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			Care), and thus are not relevant to this analysis.
L7, C7, P. 33 JP Wieske The Council for Affordable Health Insurance	2222.12	s2222.12 Minimum Loss Ratio Standards This section applies the newly proposed 70% loss ratio to all individual health insurance products. We have issues both with the proposed 70% loss ratio itself, as well as the application of this provision. While it is easy to assume a 70% loss ratio is appropriate, the truth of the matter is that the number is too high. Appropriate loss ratios insure solvency, provide resources to properly manage a carrier, and in fact can actually lead to lower health insurance premiums. For example, a recent CAHI study, Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector by Merrill Matthews, demonstrates that consumers receive good value for the money spent on administrative costs in the private sector. Also, as companies invest significant amounts of money to assist the consumer with making more informed decisions about healthcare through price transparency and quality indicators, such high loss ratios would allow for little or no investment to be made in the California market as these costs are not currently a component of the loss ratio calculation. We would urge you to consider the NAIC product-based approach listed above.	The Commissioner respectfully rejects this comment The Department has reviewed the referenced CAHI study. While there are certainly administrative differences between Medicare and private insurance, the fact remains that many of the administrative functions shared in common between the two systems, Medicare nonetheless achieves greater administrative efficiency, even when other factors are taken into consideration. In this regard, please see the testimony of Ms. Elizabeth Abbott at page 55 of the transcript of the September 19, 2006 hearing in this matter (this testimony is set forth verbatim in this summary of comments.) In her testimony, Ms. Abbott, a former administrator for the Centers for Medicare and Medicaid Services in San Francisco, stated that "the way that *[Medicare]* achieved such remarkably low administrative expenses is we contract much of that claims work and customer service and auditing and all those kinds of things in the insurance industry out to contractors. And among those contractors are some of the people that you have interaction with, Blue Cross, Aetna, Blue Shield, are all Medicare, were at one time, and in many cases still are, Medicare contractors." This is evidence for the proposition that the private insurance industry can achieve administrative efficiencies similar to those obtained in

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			the Medicare program. After considering the NAIC recommendations, and considering the practices and experiences of other states, the Commissioner determined that a 70% loss ratio would more accurately describe a reasonable relationship between benefits and premium, given the nature of the California insurance market and the needs of California consumers, for the reasons set forth in the Initial Statement of Reasons. Thus, the Commissioner respectfully rejects the suggestion offered by the commenter.
L8, C1, p. 36-39 James Oatman, Assurant Health ↓	2222.12	As a company, we have serious concerns with an increase in the minimum loss ratio for individual health insurance policies to 70 percent. We recognize the intent of the proposed regulation is to provide additional consumer protections for individual health insurance purchasers. While we recognize and support well-intended regulation for this purpose, our national experience and expertise in this market indicate the proposed regulation would have unintended consequences leading to significant market disruption, driving many individuals and families into the ranks of the uninsured – none of which would result in the best interest of any consumer.	The Commissioner respectfully rejects this comment. The Department has determined that an increased loss ratio level, in addition to providing the reasonable ratio of benefit to premium required by statute, also will support those market participants who are already achieving loss ratios at or above the new, 70%, level.
↓		The proposed 70 percent loss ratio is neither consistent with what a majority of the states currently have in statute or regulation nor is it consistent with current NAIC model law 134 -1, Guidelines For Filing Rates for Individual Health Insurance Forms, which recommends a loss ratio of 55 percent for guarantee renewable policies. An examination of other states that have a	After considering the NAIC recommendations, and considering the practices and experiences of other states, the Commissioner determined that a 70% loss ratio would more accurately describe a reasonable relationship between benefits and premium, given the nature of the California insurance market and the

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		loss ratio in place equal to or greater than 70 percent would demonstrate a market with fewer operating carriers, limited product choices for consumers and higher than average insurance premiums. By most standards, California presents a viable, growing and competitive individual health insurance market. In fact, according to a recent America's Health Insurance Plan study, California is ranked number one for affordability in the individual medical market. The California market offers the least expensive coverage for a single individual policy and also ranks seventh in family medical coverage. Implementing a 70 percent loss ratio would reverse this trend by ultimately requiring carriers to make a decision whether to conduct business in the state. More important, many consumers would be left without coverage as product choices in the market would become limited and cost prohibitive.	needs of California consumers, for the reasons set forth in the Initial Statement of Reasons. Thus, the Commissioner respectfully rejects the suggestion offered by the commenter.
↓		There are several factors that need to be considered when looking at minimum loss ratio requirements in terms of serving the interest of the consumer: These include, but are not limited to: • **Affordability:** The primary concern of the consumer is the price of the product and the benefits available relative to the premium. Higher loss ratios reward carriers that pay for unnecessary care, pay for services not covered under the contract, and do not investigate fraud and abuse in the health insurance system. The result is that consumers pay higher premiums by subsidizing inefficiencies in lieu of gaining more	The Commissioner respectfully rejects this comment, because, while higher loss ratios provide a greater return of value to the policyholder, competitive forces in the market provide incentives for insurers to develop efficient claims practices, including the prevention of fraud.

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		benefits per premium dollar.	
↓		• **Competition:** Inevitably, increasing the minimum loss ratio for individual health insurance policies to 70 percent would severely restrict competition in the market. Certain carriers would be forced from the market entirely, while others would curtail the availability of flexible, affordable products. New carriers would be barred from entering the market while existing carriers would be discouraged from introducing new products or entering into new markets. The proposed rule change would not allow these carriers to effectively manage the expense ratios on new block of business to expected longer term levels.	The Commissioner respectfully rejects this comment. Because a lifetime anticipated loss ratio is used, insurers will actuarially be able to manage the loss ratios on new blocks of business, as the "lifetime anticipated" actuarial method takes future trends over the lifetime of the product into account. The Commissioner believes that the improved loss ratio will support innovation and availability, as many insurers already provide reasonable return to their policyholders by operating above the 70% loss ratio minimum.
↓		**Managed Care:** There is no direct correlation between the loss ratios of a Health Maintenance Organizations (HMO) and an indemnity or insurance carriers. An HMO typically incurs its managed care expenses as claims expenses where an insurer considers them an expense. These include such items as network management, disease management, utilization management and case review. The proposed change represents a decided advantage for HMOs in the California market. Insurance companies need to sustain a lower loss ratio to compete in the market against HMOs.	The Commissioner respectfully rejects this comment. This loss ratio regulation is not based on managed care loss ratios; instead, it reflects the requirements of the Insurance Code, requirements which are quite different from the method by which loss ratios are regulated by the Department of Managed Health Care (regulating administrative costs across an aggregated book of business.). The statutory and regulatory structures of health insurance versus managed care are so different that comparisons between them are of limited value in discussing loss ratio regulation.

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↓		• **Customer Service:** Individual purchasers do not benefit from increasing loss ratios. In effect, an increase in the loss ratio requires carriers to reduce expense ratios. This requires carriers to cut back on services to individuals and families who do not have access to employee benefits or a human resources department for claims service and benefit information. Assurant Health provides this through customer call centers and Internet service on a member-by-member basis. A higher loss ratio reduces the available resources carriers would have to meet the needs of their customers. This would lead to disgruntled consumers, an increase in consumer complaints and potentially poor decision making on behalf of the consumer.	
↓		• **Marketing:** The process of purchasing insurance should be seamless. Assurant Health invests in advertising and E-commerce to bring awareness of its products to the buying public. This is a critical expense to create an informed consumer on the value and availability of individual health insurance. Assurant Health also engages in licensing agreements with agents on a statewide basis. Agents play an important role with customers acting as a trusted advisor to assist navigating the	The Commissioner respectfully rejects this comment because these marketing expenses appropriately are considered as part of the administrative overhead of a plan. Achieving administrative efficiencies will make sufficient funds available to adequately pay customer advisors.

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		application, underwriting and claims processes. A 70 percent loss ratio does not allow insurance carriers enough margin to adequately pay highly qualified customer advisors.	
↓		**Individual Major Medical** It is Assurant Health's contention that the proposed increase in the allowable loss ratio from 50 percent to 70 percent will have a disparate impact on smaller carriers in the individual medical health insurance market. It seems the Department has not taken into consideration two critical market factors: 1) a smaller carrier has a higher per dollar claims expense compared to a large carrier; and 2) a larger carrier can leverage its group practice to offset certain administrative, managed care and claims expenses. Taken collectively, the increase in the loss ratio standard would create a significant competitive advantage for larger carriers – or more accurately, discriminate against smaller carriers marketing in California. The proposed change is entirely pro big-business. Assurant Health recommends the following changes: 1. Apply a sliding-scale loss ratio standard based on a carrier's market share ➢ 60% for market share 5% or less ➢ 65% for market share 6-10% ➢ 70% for market share 11% or greater; 2. When determining the loss ratio, allow for managed care expenses and cost containment	The Commissioner respectfully rejects this comment, because the proposed market-share based sliding scale would be difficult to incorporate as a factor in a lifetime anticipated loss ratio, would lack certainty and clarity, and would cause an insurer's loss ratio requirements to fluctuate unpredictably as other market participants enter or leave the market, or merge and change respective market shares of other participants. The Commissioner also respectfully rejects the suggestion that managed care expenses be incorporated as a factor, as such expenses are the province of entities under the jurisdiction of the Department of Managed Health Care, not the Department of Insurance. Further, a premium offset for applicable taxes and fees would not be consistent with the requirement of Insurance Code section 10293 that the ratio between benefit provided be reasonable to the amount of premium charged.

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		expenses to be included in claim expenses and allow for a premium offset for applicable taxes and fees.	
L9, C2, p. 43 Peggy Camerino, United American Insurance		The *Policy Statement Overview* also provides …the legislative mandate of a reasonable relationship between premium charged and benefits received requires that the loss ratio requirement be raised in order to support the individual hospital, medical or surgical insurance market and ensure that these consumers obtain fair value for their hospital, medical or surgical insurance dollar. We reject the notion that the loss ratio requirement must be raised "in order to support the individual…market." A significant increase in the loss ratio, as required in §2222.12, particularly if applied retroactively does not support the individual hospital, medical or surgical market. High minimum loss ratios do not realistically account for substantial costs to insurers such as premium taxes, administrative costs, marketing and acquisitions costs. Excessively high loss ratio minimums stifle the insurance market. Appropriate loss ratio requirements allow insurers to operate in	The Commissioner respectfully rejects this comment. A reasonable loss ratio supports those market participants who are already operating at or above the minimum loss ratio amount, and by so doing effectuates the intent of Insurance Code section 10293, by assuring a reasonable return of benefit. After considering the NAIC recommendations, and considering the practices and experiences of other states, the Commissioner determined that a 70% loss ratio would more accurately describe a reasonable relationship between benefits and premium, given the nature of the California insurance market and the needs of California consumers, for the reasons set forth in the Initial Statement of Reasons. Thus, the Commissioner respectfully rejects the suggestion offered by the commenter.

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		a competitive market, which provides consumers with real choice and fair value for their insurance dollar. We urge you to consider the NAIC model loss ratio standards, which set the loss ratio based on the product, and are more appropriate to the health insurance market.	
Topic 8: Refund of Premium			
L7, C9, pp.34, JP Wieske The Council for Affordable Health Insurance	2222.17	s2222.17 Notice to Insurer In this section, the California Department requires carriers to either cease issuing the policy form or to increase benefits if they are not in compliance with the new loss ratio standards. First, requiring carriers to cease issuing the policy by definition creates a closed block of polices and is not favorable to consumers. Second, we believe carriers should also be allowed to provide a refund of insurance premiums to policyholders rather than only adjusting benefits.	The proposed amendments to this section are nonsubstantive editorial changes solely to enhance readability. No change is made to the substantive regulation, which has been in place since 1962. The Commissioner has the authority described, under Insurance Code section 10293, to withdraw approval of individual or mass-marketed policies of disability insurance "if after consideration of all relevant factors the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged." However, an option to refund premiums does not appear to be consistent with the extent of authority granted by this statute. Further, the Commissioner notes that, since the standard of reasonability is based on a lifetime anticipated loss ratio, a policy form that does not meet the standards can be brought into compliance by

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			adjusting benefits and/or premiums on a going forward basis, so that the lifetime ratio comes within the reasonable range. In light of the flexibility of adjustment afforded by the use of a lifetime anticipated loss ratio, the Commissioner respectfully rejects the suggestion presented by this commenter.
Topic 9: Competitive Impacts			
L1,C12, P.7 Ann Eowan, ACLHIC ↓		While ACLHIC has no further requested changes to the text of the proposed regulations, we would like to comment pursuant to page 9 of the Informative Digest requesting proposed alternatives that would lessen any adverse economic impacts on the individual health insurance industry. We would raise the issue that the Commissioner currently has the authority to define what is reasonable in relation to the premium, pursuant to Section 10293 of the Insurance Code, in a manner different than that proposed in 1962 and reflective of the competitive realities of our existing individual health insurance market. In 1962, when the current regulations were adopted, HMOs were not yet part of the marketplace. Since 1975, there has been a bifurcated regulatory market. Health care service plans (or HMOs) are regulated now by the Department of Managed Health Care (DMHC), while indemnity or preferred provider organization (PPO) products continue to be regulated by the Department of Insurance.	The Commissioner respectfully rejects this comment. The Legislature has created two different regulators for health care. The provisions of the Health and Safety Code and Insurance Code regarding loss ratios are not congruent; the Insurance Code provides for regulation of the relationship between premium and benefits (although only in individual policies), while the Health and Safety Code gives the Department of Managed Health Care, in contrast, authority over the administrative expenses of health plans. Given these fundamental differences between the respective grants of statutory authority, and the difference between the managed care and insurance models, comparisons between managed care regulation and insurance regulation in California are of limited value. The Commissioner's determination regarding amending the loss ratio amount has been based on an evaluation of the health insurance industry in California, and the similar experience in other states, not on the

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			administrative costs of managed care plans. (Continued in next cell, immediately below)
↓		The standards in Section 10293 are not applicable to health care service plans, which compete in the individual market with health insurers for enrollees. Rather than a minimum loss ratio that is applied to individual policy forms, the Legislature instead imposed a different standard on health care service plans in that the Knox-Keene Act prohibits excessive administrative expenses. In regulations adopted by the DMHC, excessive administrative costs are those that exceed 15% as averaged over the entire book of business of the health care service plan, including individual, small group and large group business, as well as government health plans. The definition of "administrative expenses" in the DMHC regulations excludes taxes and profit. Should a health plan exceed the 15% goal, they have an opportunity to justify such deviation to the Director, who can approve it. Several consumer and provider advocates that have testified on this issue before the Commissioner appear to be confused about these differing standards, assuming that health care service plans are subject to an 85% minimum loss ratio standard. Obviously, this is not the case.	(Continued from cell immediately above.) The Commissioner makes his determinations in this matter based on what is reasonably necessary to accomplish the purpose of the Insurance Code, in this case section 10293. While efforts are generally made to harmonize with the Department of Managed Health Care's regulation of the managed care industry, the difference in the governing statutes sometimes mandate different results, results which may have competitive significance. However, in addition to operating under different statutory structures, there are fundamental differences between the managed care and insurance products which confers different competitive positions on each. For example, managed care plans are required to provide the benefit package mandated under the Health and Safety Code, a requirement not imposed on plans regulated by the Department of Insurance. (Continued in next cell, immediately below.)
↓		The minimum loss ratio standards as currently conceived by these proposed regulations would thus impose a much higher standard on health insurers and their individual health insurance products, because a 70% loss ratio would apply to each individual policy form, rather than	(Continued from cell immediately above.) The fact that the Department of Managed Health Care's regulation of administrative cost is based on the health plan's entire book of business is a result of

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		allowing an average percentage across an entire book of business. A loss ratio, by definition, would require all administrative costs, including taxes and profits, to be limited to the amount over 70%.	the provisions of the Health and Safety Code, and therefore do not apply to an analysis of insurers under the jurisdiction of the Department of Insurance. (Continued in cell immediately below.)
↓		These differences in regulatory requirements can have significant adverse economic impacts and competitive disadvantages, particularly if the regulations continue to retroactively apply new and higher loss ratio standards to existing policy forms that were priced under the current 50% loss ratio standards. Not only would new products be priced according to the higher standard, resulting in less choice of benefit plans, but older policy forms would also have to raise their prices to meet the 70% standard due to fixed administrative costs that were anticipated in the original pricing. This change if required to be applied to lifetime loss ratios would imply that future premiums must be priced to offset the past years where the 50% loss ratio was exceeded but the actual experience was between 50% and 70%. Increasing premiums to meet the new requirements of these regulations would not only place health insurance products at a competitive disadvantage in the individual market compared to their competitors regulated at the DMHC, it would have a negative impact on consumers wishing to purchase indemnity or "PPO" products from health insurers.	(Continued from cell immediately above.) Further, because Insurance Code section 10293 provides, in pertinent part, that the Commissioner may "withdraw approval…of an individual..policy" if "the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged," *[emphasis added]* the Commissioner has determined that, to effectuate the statutory intent of section 10293, each policy form must comply with the minimum loss ratio requirements, because, otherwise, if compliance was based only on the average performance of a book of business, some policyholders would not receive the benefit of the loss ratio requirement. The Commissioner has determined that it is the intent of Insurance Code section 10293, to ensure that each consumer will obtain the advantages of a reasonable relationship between premiums and benefits. (Continued in cell immediately below.)
↓		The alternatives facing health insurers required to meet these new regulations are also not appealing from a consumer point of view. Carriers could be faced with eliminating or adjusting richer product offerings available to consumers, such as low or no-deductible products, reducing commission structures that have already been agreed on, utilizing stricter underwriting criteria or making	(Continued from cell immediately above). Existing policies continue at the 50% loss ratio unless they seek a rate increase. At the time of a rate increase, typically caused by an increase in medical benefit expenses, the plans are already re-evaluating and adjusting their actuarial assumptions in justifying

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		cuts in care management programs that are administratively expensive but provide great advantages to patients in improved health outcomes. None of these alternatives are in the best interest of the consumer, or ensure that they obtain "fair value for the {health} insurance" as is the intent of the regulations. ACLHIC urges the Commissioner to consider alternatives that would place health insurers at regulatory parity with health care service plans regulated by the DMHC. Absent absolute parity, ACLHIC would strongly advocate for the changes recommended in this comment letter to reduce, as much as possible, the negative economic consequences to one segment of the individual health insurance market.	their new rate. Therefore, the Commissioner determined that it would be appropriate to require that the actuarial structure of the policy be also adjusted at that time to reflect a 70% loss ratio, as other adjustments are concurrently being made. The Commissioner has determined that the increased loss ratio can be accomplished through greater efficiency in managing administrative expenses. Similarly, the proposed regulation has been modified to permit insurers the option of including disease management expenses in the calculation of reasonability.
Testimony of Anne Eowan at September 19, 2006 public hearing pp. 39-42		MS. EOWAN: Okay. In terms of point 19 if I Page 39 may in shorthand, I was looking at this first and thinking that the fact that you had stricken all the standards that apply to policies with premiums below 7.50, that maybe there is a different exhibit that should be included and put back in. But some of our actuaries have indicated that perhaps the exhibits have changed. So we're suggesting this language to more accurately reflect apparently what is current practice. So this was just meant to be helpful in that regard. So those are the substantive comments in terms of the actual language in the regulations. We do want to comment, as you've asked for comments, in the Informative Digest on competitive impacts. As I mentioned at the June 1st hearing on this, there is a different competitive marketplace with regards to this issue between products that are sold and approved by the Department of Managed Healthcare and those that are approved by the Department of Insurance. And	Ms. Eowan's testimony at the hearing parallels her comments in the above letter. The above responses to her comments are incorporated herein by reference.

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		the way this Department since 1962 has decided to deal with their current authority under statute is to develop the minimum loss ratio per policy, and you certainly have a right to do that under existing law. Page 40 However, in that intervening time, as you know, HMOs have come on the scene, a new regulatory department has come on the scene. And as was mentioned previously by Mr. Lindsay, under the Knox-Keene Act, what healthcare service plans, whether they be PPO regulated under the DMHC or HMOs, are subject to is language in the statute that says that they can't have excessive administrative costs. And that is defined by regulation by the Department of Managed Health Care. So rather than deal with each policy form at a minimum loss ratio per policy form, which deals with individual products, the way the Department of Managed Healthcare deals with it currently is to average out over an entire book of business, whether it's large group, small group, government-type programs, what they would consider to be administrative costs as they've defined it, which excludes taxes and profits. And then says okay, you have to, over your entire book of business, meet this goal of 15 percent. And if you can't meet it then you have to justify it. So it's a target that they expect them to achieve, but you can justify it if there is some reason for you not to meet that 15. Well, you can see because that's a much -- it's not that it's a lower standard, it's a different Page 41 standard. And I would say that the minimum loss ratio is a much higher standard than that. And it directly impacts with the kind of products you are going to design, and I'm not going to repeat Mr. Lindsay's comments in that regard. But clearly it would impact what type of products are designed, to have a 70 percent loss ratio to apply to an individual policy form. So we would ask that you would take that into account. And while the Department has looked at developing minimum loss ratios as their way to determine	

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		what benefits are reasonable in relationship to the premium, you are not tied to that. There could be some sort of parity in terms of the regulation between the two departments as well. And we just would like you to think in terms of the competitive impacts this would have on indemnity-type products, depends on whether or not you look at our letter and the concerns that we have raised. I do think that we don't at the end of the day want to make DOI-licensed products far more expensive than DMHC-licensed products and create a competitive disadvantage to be licensed at the Department of Insurance. And so with that I think I'll wrap up my comments.	
L2,C1, p.17 Steven Lindsay, CAHU ↓	2222.12	**Policy Issues:**: First and foremost is the implementation of these regulations as proposed will lead to more uninsured than currently exist in California. They will, as drafted, cause the premiums to increase faster than they presently are and additional insured persons will switch to higher deductible plans as a way of managing the premium costs or drop coverage all together. We believe this is not the result the Commissioner is seeking.	The Commissioner respectfully rejects this statement, because it implies that that an increased loss ratio will result in a worsening of the rate of increase in medical premiums. Instead, the Commissioner has determined that an increase in the minimum loss ratio level will support those insurers currently above the minimum level, and encourage all insurers to achieve greater efficiency in their operations so that an increased amount of funds can be designated for claims.
↓		The Commissioners stated belief of universal comprehensive medical benefits fly's in the face of the reality on the ground. All individuals and employers including government entities are reducing benefits. The cost to provide the benefit level the Commissioner desires is universally unaffordable and even if done would suck the resources out of all other government and private programs such as education, prisons, roads, emergency preparedness, retirement, and public safety.	The Commissioner respectfully rejects this comment, because the mandate of Insurance Code section 10293 that a reasonable relationship exist between benefits and premiums apply to all applicable policies, regardless of whether the policy plan provides extensive or limited benefits.

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↓		At present, California has one of the most affordable and competitive individual markets in the nation. California carriers have been in the forefront of designing products that meet the needs of a wide array of individuals in the face of relentless double digit premium increases. It costs money to develop new and innovative product and as with all new products some are very successful and other are not. Some will meet the proposed 70% loss ratio and other will not. Some will take two years to get there and others will take six or eight. The list of variables which affect this is long and distinguished. *The proposed standard is an innovation killer.* It will discourage experimentation with benefit plan designs for fear of not hitting the proposed minimum loss ratios and ongoing harassment by the Department to meet an exceptionally unrealistic standard when applied to specific individual benefit designs. The proposed standard encourages a one size fits all that time and time again have been shown to impede and disrupt the distribution of new cost saving programs and innovative care experimentation.	The Commissioner respectfully rejects this comment because the Commissioner has determined that raising loss ratio levels, required for the benefit of the consumer, will also encourage innovation in insurer efficiency, controlling administrative costs so that greater benefits can flow to policyholders. Further, the regulation has been modified so that disease management expenses may be included in the calculation of benefit: this provision encourages innovation in the development of disease management programs that will improve patient outcomes, and ultimately reduce utilization.
↓		A number of states such as New York, New Jersey, Massachusetts have no innovation in their markets and the resulting premiums discourage all but the rich from purchasing individual coverage. They have the most expensive individual premiums in the nation. Transport that to California where we have more diversity in cultures and within those groups', cultures that do not value insurance coverage, more individuals that are on the lower rungs of the economic ladder and you would disenfranchise them even considering the purchase of individual health insurance coverage.	The Commissioner respectfully rejects this comment, because the states mentioned are "guaranteed issue" states, such that insurers cannot filter applicants through medical underwriting. California is not a guaranteed issue state, in the individual market, companies undertake medical underwriting to limit their risk. Given these differences, the Commissioner asserts that the alleged lack of innovation in the states mentioned are not due to their required loss ratios, but instead due to other factors not shared with California.

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↓		The one thing that has done the most to prevent the destruction of the individual market is the willingness of the carriers to listen to their insured when they demand other more affordable choices. It is much easier to meet the proposed loss ratio and do chronic illness management, privacy compliance, special marketing programs for the uninsured, provide extensive RX formularies, meet the vast array of regulatory requirements, claims adjustment, provider contracting and monitoring, fraud detection etc. when you are getting $1000 a month rather than $600 a month in premiums. One could argue that this proposed standard creates a perverse incentive to raise benefits and increase premiums in order to get the necessary revenue to cover "administrative costs".	The Commissioner respectfully rejects this comment. In a high-cost environment, driven by a rate of medical inflation higher than the general rate of inflation, fixed expenses of marketing and administration are accommodated by a steeply increasing premium.
↓		One of the false assumptions in this process is that administrative expenses take away from the delivery of quality and appropriate medical benefits or that they are unnecessary. Administrative expenses are not in and of themselves bad. Many of the administrative activities are focused on reducing or containing medical costs, meeting minimum financial requirements, developing new products for a changing market, fraud prevention and detection, reviewing advances in medical technology, outreach and marketing to difficult to insure populations or groups resistive to purchasing insurance coverage, etc. will be cut in order to meet the arbitrary minimum loss ratios standard proposed.	The Commissioner respectfully rejects this comment, particularly with regard to the assertion pertaining to an alleged assumption. The Commissioner recognizes the role paid by administrative activities; the proposed loss ratio recognizes this, while providing an incentive for efficiency so that reasonable benefits are provided to the consumer.
↓		The minimum loss ratios as proposed will significantly hinder carriers from investing in IT, electronic medical records, and disease specific programs to increase compliance with medical treatment recommendations, medical review panels, etc. which benefit all insured by	The Commissioner respectfully rejects this comment. Investment in information technology and electronic records will be recouped by insurers through increased efficiency. Also, competitive requirements drive

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		controlling costs and improving benefits.	insurers to adopt such systems in order to achieve efficiency. Further, the proposed regulation has been revised to allow consideration of disease management expenses as a benefit.
↓		These regulations as drafted provide no limits to the additional administrative expenses and burdens the legislature can mandate. When one reviews the last seven or eight years of legislative history around medical cost mandate, whether they be benefit mandates or process mandates, you find a unending stream of bill introduced which attempt to address some perceived defect in medical care delivery or insurance or reporting requirement all of which add to the administrative burden but with rare exception have had no meaningful impact except to increase administrative costs and make health insurance more unaffordable.	The Commissioner respectfully rejects this comment. The Department does not have the authority to restrict the Legislature's ability to enact medical cost mandates.
↓		California is blessed or cursed as it were, to have two different regulators for medical coverage products. The Department of Managed Health Care has a system in place addressing this same issue that has worked well without burdening the entire market as these regulations will. Their system does not look at a single line of business in a vacuum; rather they look at the carriers business as a whole encompassing large group, small group and individual business. They look at administrative costs excluding profit if the carrier is a for-profit and excluding those administrative functions transferred out to the physician group. Thus acknowledging profit is not an administrative cost and HMOs are responsible for only part of the administrative costs. The rest is paid in capitation payments to provider groups and all is not directly	The Commissioner respectfully rejects this comment. The Legislature has created two different regulators for health care. The provisions of the Health and Safety Code and Insurance Code regarding loss ratios are not congruent; the Insurance Code provides for regulation of the relationship between premium and benefits (although only in individual policies), while the Health and Safety Code gives the Department of Managed Health Care, in contrast, authority over the administrative expenses of health plans. Given these fundamental differences between the respective grants of statutory authority, and the difference between the managed care and insurance models, comparisons

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		spent on medical care. In the case of an insurer most of those administrative functions the HMOs transfer to provider groups are preformed by the insurer and are accounted for as administrative cost. Thus we have an apple and an orange comparison that distorts the true cost of administration or in the reverse the true medical loss ratio.	between managed care regulation and insurance regulation in California are of limited value. The Commissioner's determination regarding amending the loss ratio amount has been based on an evaluation of the health insurance industry in California, and the similar experience in other states, not on the administrative costs of managed care plans.
↓		While the Commissioner is accurate that group products have a higher medical loss ratio than individual products, he is mistaken in his assumption as to the reason. The reasons for this "disparity" are two fold. First is the actual difference in revenue between group insurance and individual insurance. Group insurance premiums are on the whole higher than individual premiums because the benefits are better and the policy is guaranteed to be issued. Second, individual coverage is medically underwritten, benefits are usually lower because only the individual is paying the premium and therefore the premiums and claims are smaller while expenses are higher.	The Commissioner respectfully rejects this comment, because the fact that individual policies are medically underwritten means that the insurer has a means of tempering their risk exposure, a means not available in group policies. The added benefits of group policies also reflect the marketing power inherent in having a large employer, instead of an individual, bargaining for coverage.
↓		In item two of the problem description the Commissioner contends that both premiums and out of pocket expenses have increased and goes on to sight national figure on the increase in health care spending on a per person basis. He also quotes figures highlighting the percentage increase in total average annual growth rates and more specifically the increase in individual insurance premiums in California from 1997 to 2002. All of which are accurate and is the foundation for his assertion, that individuals are	The Commissioner respectfully rejects this comment. The figures presented demonstrated the fact that premiums, out-of-pocket expenses, and health care spending have recently shown substantial increase. Although this is true for all policy types, the Insurance Code only provides the Commissioner with authority to regulate the relationship between premium and benefits for individual policies. While all health insurance purchasers must deal with these problems,

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		bearing an increasing burden. What is missing leading is the comparison of the whole market to only individuals purchasing coverage. These same trends have been affecting all health insurance purchasers' not just individual insurance purchasers. All purchasers of health insurance have had to deal with higher premiums and reduced benefits.	Insurance Code section 10293 only permits the Commissioner to address the individual market.
↓		The Commissioner then goes on to compare the percentage increase in individual health insurance premiums to the increase in other goods not to the increases in group insurance coverage. The comparison of percentage increase between individual and group insurance coverage would show both types of coverage have experienced similar increases thus undermining his one sided assertion that individuals are alone in their increasing burden. The picture is then further muddied by comparing individual health insurance premiums with the percentage increase in other goods implying only individuals have suffered this disparity. This would have been a valid comparison had both group and individual health insurance premiums been included, however unuseful it might have been to the Commissioner's contentions .	As stated above , the Insurance Code only provides the Commissioner with authority to regulate the relationship between premium and benefits for individual policies, not group policies. While all health insurance purchasers are confronted with the burden of medical inflation, Insurance Code section 10293 only permits the Commissioner to address the individual market.
↓		In the third point of the problem the Commissioner asserts that individual coverage is the market of last resort. California has had sense 1992 a high risk purchasing pool for persons who are uninsurable. In addition California mandates all employers providing health insurance coverage with two or more covered employees to provide Cal-Cobra or if over 20 employees a combination of Federal Cobra and Cal-COBRA for 36 months in the event of employee termination or death or divorce for dependents. This	The Commissioner respectfully rejects this comment. The individual market is the market of last resort for those without prior creditable coverage, or for those for whom their COBRA, Cal-COBRA, or other options have run out.

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		coverage is the same as the employers. In addition to this Federal law mandates provision of HIPAA coverage to all who complete COBRA or CAL-COBRA coverage. This coverage lasts until age 65 or premiums are not paid. HIPAA coverage is mandated to reflect the two most popular products in the individual market for each carrier that is required to offer HIPAA coverage. In addition all carriers are required to offer conversion coverage to their enrollees as an option to HIPAA. Which means that most individuals have had the opportunity to choose products other than just individual coverage.	
↓		The Commissioner then goes on to assert that individual insurance policies are difficult to get because of medical underwriting. While some persons will not qualify because of preexisting conditions (they are then eligible for the high risk pool) the vast vast majority who apply for individual coverage are issued policies. A survey of CAHU members indicate that no more than five to ten percent are ultimately rejected. This is confirmed by the small numbers in the high risk pool even considering that sometimes the high risk has a waiting list.	The Commissioner respectfully rejects this comment, because, notwithstanding the reported amount of persons rejected for individual coverage through medical underwriting, this low percentage, when applied to the size of the applicant pool, yields a significant number of applicants who are unable to obtain individual coverage, coverage they would have been able to obtain if they qualified for a group plan.
↓		The Commissioner goes on to address affordability of coverage which then addresses availability of coverage. Cost of coverage is just as much a deterrent to coverage as medical underwriting! Most individuals pay for their own coverage while those insured through the work place pay only a small to medium portion of the premium. Two pockets rather than only one. As a result, most individuals choose to purchase higher deductible lower benefit products in order to control	The Commissioner respectfully rejects this comment. The current problems with affordability require that more premium dollars be applied to benefit, so as to maximize the value of each premium dollar, and moderate the increase in premiums. The Commissioner respectfully rejects the assertion that plans that offer lower benefit structures necessarily must operate at a lower loss ratio. Through efficient

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		the premium cost. They choose, as the Commissioner defines it, to be under insured rather than to be uninsured. The false choice is great insurance or underinsured. **The real choice is lower benefits or no benefits.**	administration, adequate loss ratios can be maintained, achieving reasonable proportional burden sharing between the insurer and insured. Further, the Commissioner understands that some purchasers may choose to accept lower benefit plans in order to achieve cost savings; the purpose of the proposed regulation, however, is to ensure that they continue to receive a reasonable proportional benefit.
↓		The proposed regulations only compound this access and affordability problem by increasing premiums and providing perverse incentives for carriers to increase both benefits and premiums in order to compensate for the increased loss ratio requirements.	The Commissioner respectfully rejects this comment, because competitive pressures in the marketplace will provide incentives to undertake loss limiting measures, such as administrative procedures to detect and eliminate fraud.
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 7-8		We think that inevitable results of the regulations as they are currently drafted will be an increase in insurance premium costs at a rate faster than we currently see in the marketplace today. California has by its very nature probably the most competitive individual marketplace in the nation. We have on average on any given day somewhere between seven and ten active competitors who are actively writing insurance in the individual marketplace. I know there are many more who have products filed, but they are not marketing them. Most of our individual carriers have a range in products from fairly rich benefits to fairly high deductible HSA-qualified products, in addition to both HMO and PPO products. We believe that it's the competition in the marketplace which controls the pricing on the products as opposed to the current 50 percent regulatory requirement. In the last 18 to 24 months we've seen a significant increase in product	The Commissioner respectfully rejects this comment, because the proposed regulation will support competition by ensuring a reasonable benefit level, as required by statute. Many carriers are currently operating at loss ratio levels above 70%.

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		development and release from the carrier community. I don't want to say almost a total reworking of products, but very close to that. 70 to 80 percent of the products I'm seeing in the marketplace today are new or modified products from the carrier community in the individual marketplace, whether that be HMO or PPO. I know today we're focused on the indemnity carriers.	
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 8-9		Our fear is that as in past hearings that we've had with the commissioner, it's clear his desire is to have a product that has a very rich benefit in it and that those products are by and large for the marketplace that purchases individual coverage unaffordable. We see folks having to make the decisions between putting their kid through college or saving for their pension plan and paying high health insurance premiums for medical coverage. The average coverage for a family of four in Sacramento county is somewhere around $11,000. And even for moderate level income folks the ability for them to hand you 20 percent of their gross income is something they just won't do. And so we've seen a move in the marketplace as premiums have increased, especially over the last four or five years of double digit rates, to products that have higher deductibles and higher co-pays and co-insurance.	The Commissioner respectfully rejects this comment, because This regulation does not set benefit levels; instead, it requires reasonable relationship between benefit and premium per statute. The Commissioner has determined that changing the loss ratio amount from the 50% level set in 1962 is necessary in light of the current environment of high medical costs and medical inflation.
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 9-10		As a result of that we've seen carriers come out with new products. And a result of that we see deterioration in the medical loss ratios as is common with all new product introductions. Out of the products that are out there in the marketplace today there are some that will survive and make it, and there are some that will go away because the benefit designs don't meet the needs, value, standards that the purchasers have for what has value to them. We are concerned that an application of a 70 percent loss ratio will become an innovation killer. When we go look at the states, especially those on the East Coast of New York,	The Commissioner respectfully rejects this comment, because the Use of lifetime anticipated loss ratio accommodates low loss ratios in early years of a product's life-cycle. Further, Comparing to guaranteed-issue states is not a relevant comparison. California is not a guaranteed-issue states, and so its insurers can select those insured though medical underwriting. The Commissioner has determined that a higher lifetime anticipated loss ratio amount will support, rather than inhibit, competition.

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		New Jersey and Massachusetts, which have regulations similar to these, we see no product innovation in those states and we tend to see product premium prices significantly higher than what we have here in California. Part of the other problem that they have back there is they have guaranteed issue marketplace in all three of those states. We don't here. But we also note that based on the regulations they have in those states, they don't have near the kind of creativity and product design in the marketplace that we have here in California. So very much a reduced number of choices.	
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 10		Even though California currently has not adopted the compatibility with Federal Rules for HSA tax deductibility, we still see a significant number of HAS products available for sale here in California, just based on the federal -- the benefits in the federal tax deductibility. One of the things that we think, and the agent community thinks, that in California has made our individual marketplace more vibrant has been the willingness of the carrier community to take the risk with new products. While we as agents sell these products and you go talk to folks and you ask them if they like the high deductible, their answer is no. But if you ask them if they would rather pay $1,000 a month as opposed to the 500 or 600 a month premium they are currently paying, they say no. So they have, in effect, spoken with their feet. They have chosen in a marketplace that offers both kinds of products to pick a higher deductible, at least benefit rich product.	The Commissioner respectfully rejects this comment, because the loss ratio supports a reasonable relationship between premiums and benefits, and so acts to moderate, rather than increase, premium increases. Also, the fact that a lifetime anticipated loss ratio takes into account variations in loss ratio over the lifetime of a product means that a reasonable loss ratio will not inhibit innovation, even if new products show a lower loss ratio amount in their early years.
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing		**Page 11-12: The Commissioner has determined that competition within the marketplace will encourage efficiency to control overhead costs.** Now the problem is as the marketplace moves that way, when you work on a percentage basis, when you bring in less revenue, you have less money for overhead. And so that 30 percent gets significantly less when I have a $600 premium than when I have a $1,000 premium. And so on	The Commissioner respectfully rejects this comment, because

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pp. 11-12		some level there may even be some perverse incentives in this kind of regulation to put richer products on the street in order to get $1,000 in revenue so I have more money to actually cover my overhead.	
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 13-14		We're also concerned that many of the smallest employers in the state purchase individual products. And that one of the gifts that California has always brought to the table is a very vibrant, small employer marketplace. For all of the advantages and p.13 disadvantages of our huge immigrant communities, one of them is they like being self-employed. Their picture of coming to America is to own their own business and run it. And as we add cost to the premiums, I think we in fact discourage those folks from setting up their own shop and working for somebody else. And so I think on a whole in the economy we do a great disservice by pricing individual products in ways that they are unaffordable to those folks who want to start their own business today or tomorrow. And I would suggest to you that $1,000 a month is not an affordable premium for somebody who is opening their own restaurant or starting their own tailor shop or opening their own nail shop, fingernails shop. That those premiums are just prohibitive. So we have to have products on the marketplace that allow those folks to purchase financial coverage for both their family and their assets, which is part of what we do, we buy insurance coverage. We think that the 70 percent loss ratio lends itself towards same size fits all product design, and that as a result of that we think we'll see a significant deflation of the number of choices in the marketplace, as it's simply easier to submit products and not be innovative. Because when you are innovative, 14	The Commissioner respectfully rejects this comment, because the Commissioner has determined that assuring reasonable value, as required by Insurance Code section 10293, is an important component in assuring affordability, whatever the benefit structure of a particular plan design. Further, that a reasonable loss ratio, combined with the competitive pressures of the market, encourages administrative innovation and efficiency.

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		I can't tell you what kind of a medical loss ratio we're going to have. And I'll give you the HSA product as an initial one. I don't think anybody out there knows what the medical loss ratios on the HSA products today are going to be for how they are priced today. People made their best guesses, but we do not know how people are going to use these products. We don't know how much money they are going to spend on dental care, on vision care, on other things that are allowable under the federal regulations. And so we don't know how much money they are actually going to spend in medical care. And my guess is it will be 24 to 36 months before we have a good handle on how folks are going to use those products and what kind of medical loss ratios we're going to see and what kind of premium changes are going to be necessary or adjustments are going to be necessary to address the usage issues that we can't very well define today, I don't think.	
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 18-19		Sometimes I think that in this debate we picture the choices between great products or rich benefit products and poor benefit products. And I can assure you that that's not the choice for the folks that my members sell insurance to. The choice is between a p.19 product they can afford and no product. And that as we do things from a regulatory and statutorily point of view that add cost to the products we, in effect, make that choice more difficult for more people and we lead to more folks joining the uninsured roles, because they stop seeing value.	The Commissioner respectfully rejects this comment. The current problems with affordability require that more premium dollars be applied to benefit, so as to maximize the value of each premium dollar, and moderate the increase in premiums. The Commissioner respectfully rejects the assertion that plans that offer lower benefit structures necessarily must operate at a lower loss ratio. Through efficient administration, adequate loss ratios can be maintained, achieving reasonable proportional burden sharing between the insurer and insured. Further, the Commissioner understands that some purchasers may choose to accept lower benefit plans in order to achieve cost savings; the purpose of the proposed regulation, however, is to ensure that they continue to

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			receive a reasonable proportional benefit.
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 7-8		And while that is in large part the cost increases are led by medical cost inflation, we can and do regularly in California, on a regulatory and statutory basis, add cost to those, to the delivery of those products. One of the other pieces that the Commissioner talked about was the increase in premiums. And he chose to use the time frame 1997 to 2002. And what I found missing in that section was an acknowledgement that all products, not just individual products, went up significantly across that same time frame. That the problem of pricing people out of the marketplace is not unique to individual health insurance products. It is consistent across the whole marketplace. And so that to pick out individual products and say this is a huge problem here and not say it's a huge problem over here is to not acknowledge the extent of the issue and that we can't fix it just doing individual products. So as you define a problem, I think the p.20 problem definition here is much wider and it's one that is, in large part, a societal problem and not a regulatory problem, as we describe it. And that going to a 70 percent loss ratio does not address pricing people out of the marketplace. It adds to the problem with pricing people out of the marketplace. Then the other piece that I struggle with is the Commissioner talked about individual health marketplace of last resort for a number of folks. And that's probably the marketplace of first resort for folks. The marketplace of last resort would be the MRMIT program or high risk pool for those who are uninsured, it would be a HIPAA product, or it	The Commissioner respectfully rejects this comment, because of necessity the focus of this regulation is on individual policies, because that is the limit of authority granted by Insurance Code section 10293. Data regarding other polices is illustrative of the scope of the problem, but the problem with individuals is even more acute due the fact that purchasers of individual policies must pass through medical underwriting, and lack market power and expertise as compared to large employers, even with the assistance of an agent. The Commissioner also respectfully rejects this comment because the individual market <u>is</u> the market of last resort for those without prior creditable coverage, or for those for whom their COBRA, Cal-COBRA, or other options have run out.

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		would be a group conversion product or maybe a COBRA product would be the market of last resort. Whereas individual products for the market are first choice for those folks who are not eligible for group coverage on a guaranteed issue basis. The carriers in the state have made great efforts to have multiple pricing tiers so that they can actually insure folks who have pre-existing conditions. And that has been, from our agent's perspective, very successful. When I survey my members, they tell me that 25 no more than five or 10 percent of the folks who p.21 actually make an application, are they unable to get insurance coverage for -- through one of the normal carriers without having to go to one of these other, other avenues, at less cost than the other avenues, which I think is, in part, a testament to the low enrollment to the high risk pool in California even with the historic difficulties with waiting lists. Even when we've taken the waiting list off, the pool hasn't filled up instantly. It's taken time to fill up. And then they are serving a significantly lower number of folks today in the high risk pool than they were when we first created it because of cost increases. And we can, we can -- the cost of coverage is just as much a deterrent to people having coverage as is the price of coverage. And so when we add to that price of coverage, it's the same as carrier adding medical issues that they'll turn somebody down for. They'll move from, you know, they'll give them a 50 percent increase in premium and moving them over to we won't insure that benefit at all. There is no difference there. Because when you pass the price points that folks see a value in it or that they can afford, that's just as effective as actually labeling them as uninsurable in the p.22	

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		marketplace. And that as we move forward doing regulatory issues we should always be conscious of not doing that in the marketplace.	
L4,C2, p.22 Mark Sektnan, AIG	2222.12	The Regulations change the minimum loss ratio at which certain insurance policies will be deemed *reasonable* from 50% to 70%. New products filed in California would require a loss ratio of 70%. Due to the high loss ratio requirements and resulting constraints this requirement would deter a company from seeking approval for and offering new products. This may result in product unavailability in certain market segments (particularly lower to middle income markets), and, in California in general. We believe that the proposal to increase the minimum allowable loss ratio for new policies to 70% would preclude companies from introducing new products for consumers to choose among as it would be doubtful that any such products would be both readily marketable and structured to meet reasonable profit objectives.	The Commissioner respectfully rejects this comment because, as all market participants will be held to the same standard, market forces, increasing efficiency inspired by competition, an innovation in a sizeable market will continue to result in the development of new products.
L5, C2, p. 26 Leanne Ripperger, PacifiCare ↓	2222.12	While we currently comply with the proposed regulation without changing our rate structure or underwriting practices with existing products, we do believe that certain elements of the proposed regulation may have a significant anti-competitive impact on the individual health insurance market in California. Specifically, new entrants and new product forms to the market could be materially disadvantaged and discouraged from offering coverage in California, depending on how the department implements section 2222.12.a.2. If new products and new market entrants have to hit a 70% or higher loss ratio in the second year of the policy (as	The Commissioner respectfully rejects this comment. The use of a lifetime anticipated loss ratio takes into account the low loss ratios in the initial years of a policy due to the durational effect of underwriting, offset with the anticipated higher loss ratios in later years as utilization of benefits increase. Thus, the suggested exemption of the early years of a policy are not necessary, as the lifetime anticipated loss ratio takes this into account by projecting changing loss ratios over the life of a policy. Thus, the pricing of the

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		opposed to over the lifetime of the policy) there is a serious potential negative outcome on the individual health insurance market. For new market entrants, with no mature existing policies, second and third year rate increases will be artificially low due to the durational effect of underwriting. In later years, these carriers will need to have higher increases than they otherwise would if the loss ratio standard were phased in over a longer period of time. Over time, healthy insureds will continually purchase new, artificially low-priced coverage; leaving those who cannot purchase that coverage, to shoulder the necessary rate increases. This will lead to consumer dissatisfaction, complaints to the Department and high policy turnover.	policy will also reflect this averaging over time, thereby avoiding the adverse selection of healthy insureds seeking price advantages in new policies.
↓		For this reason, we recommend limiting the applicability of the 70% loss ratio standard to the third year of a policy form, and beyond. In the alternative, we recommend dropping section 2222.12.a.2 and enforcing a lifetime loss ratio for the policy form, which would allow lower loss ratios in the early years and higher loss ratios in the later years after acquisition costs are amortized and the effect of underwriting wears off. This would lead to a more stable individual health insurance market.	(Please see response immediately above.)
↓		If this regulation is implemented, we encourage the Department to assure existing carriers in the California market do not work towards compliance by offering unsustainably low new business rates subsidized by high rates on large existing blocks of business. If this were allowed to happen, it would create an un-level playing field by freezing small competitors out of the market and discouraging new competitors from entering the California market, thus limiting choice for	The Commissioner respectfully rejects this comment. In the current environment of steeply increasing medical expenses, it is anticipated that existing policies will eventually choose to seek rate increases; such increases will result, under the proposed regulation, in the adjustment of that policy's loss ratio to reflect the new standard.

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		consumers.	
L6, C1, p.29 David Dellinger, NAIFA-Calif.		The competitive disadvantage associated with such an increase in the minimum loss ratio will essentially place a cap on administrative costs for health insurers similar to the administrative cap currently in place under Knox-Keene for HMOs. However, the proposed regulations and the current Department of Managed Health Care (DMHC) regulations are not consistent. In the regulations adopted by the DMHC, excessive administrative costs are those that exceed 15% as averaged over the entire book of business of the health care service plan, including individual, small group and large group business, as well as government health plans. The definition of "administrative expenses" in the DMHC regulations excludes taxes and profit. Should a health plan exceed the 15% goal, they have an opportunity to justify such deviation to the Director, who can approve it.	The Commissioner respectfully rejects this comment. The Legislature has created two different regulators for health care. The provisions of the Health and Safety Code and Insurance Code regarding loss ratios are not congruent; the Insurance Code provides for regulation of the relationship between premium and benefits (although only in individual policies), while the Health and Safety Code gives the Department of Managed Health Care, in contrast, authority over the administrative expenses of health plans. Given these fundamental differences between the respective grants of statutory authority, and the difference between the managed care and insurance models, comparisons between managed care regulation and insurance regulation in California are of limited value. The Commissioner's determination regarding amending the loss ratio amount has been based on an evaluation of the health insurance industry in California, and the similar experience in other states, not on the administrative costs of managed care plans.
↓		The proposed regulations would impose a much higher standard on health insurers and their individual health insurance products, because a 70% loss ratio would apply to each individual policy form, rather than allowing an average percentage across an entire book of business. A loss ratio, by definition, would require all administrative	The Commissioner makes his determinations in this matter based on what is reasonably necessary to accomplish the purpose of the Insurance Code, in this case section 10293. While efforts are generally made to harmonize with the Department of Managed Health

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		costs, including taxes and profits, to be limited to the amount over 70%. These differences in regulatory requirements could have significant adverse economic impacts and competitive disadvantages, particularly if the regulations continue to retroactively apply new and higher loss ratio standards to existing policy forms that were priced under the current 50% loss ratio standards.	Care's regulation of the managed care industry, the difference in the governing statutes sometimes mandate different results, results which may have competitive significance. However, in addition to operating under different statutory structures, there are fundamental differences between the managed care and insurance products which confers different competitive positions on each. For example, managed care plans are required to provide the benefit package mandated under the Health and Safety Code, a requirement not imposed on plans regulated by the Department of Insurance.
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 14-15		Let's talk about -- oh, the other issue that I would note is that California is either cursed or blessed to have two regulatory systems for medical insurance as it were, Department of Managed Health Care and the Department of Insurance. The current way that the Department of Managed p.15 Health Care looks at -- they address it in the reverse as in terms of administrative costs as opposed to medical loss ratios. And my association finds that to be a better way to address that subject. And in part I'll tell you why. Many of the things that the indemnity carriers do are farmed out in our world in California, are farmed out to the provider groups. So when a provider group gets a capitation check for $5 million, there is a significant portion of that capitation check that goes for administrative expenses, for claims reprocessing, for paying claims, for all sorts of things. That does not get reflected in the administrative costs. That gets labeled as a cost of care and so would fall under the medical loss ratios. Whereas on the indemnity side of the house, the carriers themselves are doing all of those tasks. They are	The Commissioner respectfully rejects this comment. The Legislature has created two different regulators for health care. The provisions of the Health and Safety Code and Insurance Code regarding loss ratios are not congruent; the Insurance Code provides for regulation of the relationship between premium and benefits (although only in individual policies), while the Health and Safety Code gives the Department of Managed Health Care, in contrast, authority over the administrative expenses of health plans. Given these fundamental differences between the respective grants of statutory authority, and the difference between the managed care and insurance models, comparisons between managed care regulation and insurance regulation in California are of limited value. The Commissioner's determination regarding amending

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		actually paying the claims, they are the ones who are supervising the introduction of new technologies. They are the ones who are instituting the disease management programs on this. And so on the indemnity side of the house those all get dumped into the administrative category and are not looked at as medical loss ratio, or in effect punish you for a higher or lower medical loss ratio. And so if you continue to go p.16 down this road there needs to be accommodations made for those kinds of activities that are not direct care, but affect severity or morbidity of the provision of care.	the loss ratio amount has been based on an evaluation of the health insurance industry in California, and the similar experience in other states, not on the administrative costs of managed care plans.
L10, C1, p. 45 Anthony Wright, Health Access ↓	2222.12	We believe it is important that these standards are revised reflecting current levels of protection for consumers. Since the existing standards have been in effect for over 40 years, they are clearly outdated. The insurance companies and plans have complained about the difficulties they face by having two regulatory agencies oversee the health insurance market in California. However, the Department runs the risk of permitting the insurance companies to shop for their regulatory agency. It is currently possible for insurers to apply for oversight from the Department of Insurance that, with these less stringent guidelines and standards in place, is required to hold them to a lesser standard than the Department of Managed Health Care. Recognizing that there are differences in the responsibilities of the two agencies, consumers are better served by having commensurate levels of regulatory authority and standards.	The Commissioner agrees regarding the need to update the 40-year old standard to reflect the requirements of the modern market for individual health insurance.

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↓		**The Importance and Failure of the Individual Insurance Market** In the past eighteen years, Health Access has done extensive research and analysis, public education, and organizing, working with California health care consumers. In the last few years, we have spent a significant amount of time understanding the many barriers, concerns, and issues facing those in the individual insurance market. While most Californians get their health coverage through employer-based coverage or public insurance programs, many find that they don't qualify for either. One to two million Californians buy health insurance as individuals. Yet over six million Californians are uninsured, not eligible for employer coverage or public programs, and presumably finding that individual coverage is either unaffordable, unavailable (often due to "pre-existing conditions), or not worth the value provided.	The Commissioner agrees.
↓		**Insurance Commissioner's Job: Protect Consumers** Health Access understands that it is the Insurance Commissioner's responsibility to provide assurances to health care consumers that the insurance products offered are of value.	The Commissioner agrees, particularly as to the lack of market power and expertise of individual consumers.

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		Patients are not actuaries. They do not have market power, expertise, information, or ability to assess whether a product is providing appropriate value for their premium dollar. This is not just that they do not know what illnesses and emergencies might befall them, or even the likelihood of these ailments. In today's market, when many insurance products provide different benefits, cover (or don't cover) different services and treatments, and have different cost-sharing arrangements (including co-payments, deductibles, tiered formularies, and the like), it is almost impossible for an individual patient to determine if an insurance product is providing a reasonable return of value.	
↓		**Some Plans Lack Value** We are concerned that new products in both the individual and small group market are becoming attractive with their lower premiums but illusory benefits. These "skeleton plans," with limited coverage and high deductibles and cost-sharing, often fail to meet the key purposes of health insurance: to allow patients to get the care they need, to live healthier, and to safeguard their family against financial ruin. • Studies have shown that low-income and moderate-income people, when faced with even moderate cost sharing, are less likely to get needed care, to fill and take prescribed	The Commissioner agrees to the extent that any policy, irrespective of its policy design, must return a reasonable amount of benefit per premium dollar.

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		medications, to even go to the emergency room. These surveys and studies indicate that this behavior leads to worse health outcomes. • With new plans with $5,000 or $10,000 deductibles, and those with no maximum for out-of-pocket costs, some patients still find themselves in severe medical debt. In a Harvard study that showed medical problems and medical bills as a leading cause of bankruptcy, a majority of those bankruptcies caused by medical debt were filed by people who were insured. We fear that some consumers purchase these insurance products not knowing these risks. And if an insurance product does not protect the patients from the health and financial repercussions of being uninsured, is it really insurance?	
↓		**Loss Ratio: An Indicator of Value** The Insurance Commissioner, through the regulations such as the ones proposed here, needs to have the authority to reject plans that do not provide sufficient value to consumers. While not the only test, one key criteria is whether a sufficient percentage of the premium dollar goes to the patient care, as opposed to administration, profit, or operations. The nature of insurance—where people pool together to share the risk and cost of health care—means that some individuals may pay into a plan and never get a return, while others may find a major benefit. However, in the	The Commissioner agrees. The Commissioner has the authority described, under Insurance Code section 10293, to withdraw approval of individual or mass-marketed policies of disability insurance "if after consideration of all relevant factors the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged."

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		aggregate, if a significant majority of the dollars paid into the plan by consumers is not going back to them in terms of patient care, then that is an indication that the product is providing more value for the insurer than the insured. While insurers argue that administrative expenses can provide some value for consumers, such as efficiencies that provide savings on the cost of care, we would state that such savings and efficiencies would be best returned to the patient, in terms of patient care or lower premiums.	
↓		**More for Patient Care** The existing regulations already set a standard, however low. After forty-plus years, it is not just reasonable but expected to revisit that standard, and to adjust it upward. Health Access supports a higher percentage than the 70% proposed. We note that: • Many of the existing plans have loss ratios higher than that standard already. We would support proposals that took into account best practices, or even an average of where existing plans are, with a regulatory regime to encourage insurers below that threshold to change their practices. • There is one health plan (not regulated by the Department of Insurance) that has achieved administrative costs of less than 2%, and takes care of a disproportionate share of sick and elderly. The Medicare program has been	The Commissioner agrees. However, the Commissioner has concluded that a set loss ratio figure, rather than an average of current practices, will provide the benefits of greater clarity and certainty. The loss ratio level set serves as a minimum: efficient plans may deliver even higher levels of benefits to consumers.

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		considered as a model for possible health care expansions in both individual states and in the national forum. Medicare has received considerable praise for its success in providing excellent service while incurring very low levels of administrative costs. Consequently, it would not be without precedent to suggest a loss ratio similar to Medicare. It also should be noted that the Centers for Medicare and Medicaid Services (CMS) that runs the Medicare program is a small agency (around 4600 staff nationally) and they accomplish many of their program objectives through contracts with insurance companies. Several of the insurance companies that the Department of Insurance regulates in California have served as Medicare contractors; for example, Blue Cross, Aetna, and Blue Shield have delivered claims processing, audit, and customer service functions to Medicare beneficiaries while being held to very low targets for administrative expenses.	
↓		**Impacts on Consumers** We hope adoption of this rule, or that which sets a higher standard for loss ratios, would have positive impacts on consumers. In the policy conversation about health care costs, most of the focus has been on shifting more costs to individual patients and families; we think this rule appropriately focuses the discussion on getting better value for our dollar by taking a close look at where our premium dollars go, and how they are	The Commissioner agrees with the comment, inasmuch as it seeks to ensure that consumers receive a reasonable return in benefits for their premium dollar.

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		spent. Secondly, we have been considering whether the profitability of some of these plans is because of aggressive underwriting criteria; we found many Californians who were denied coverage because of so-called "pre-existing conditions" that many would consider minor. If there was a higher standard for loss ratios, we expect that some insurers would have less competitive pressure to deny people who might have the possibility of needing care and coverage. This action has the potential to expand coverage.	
Testimony of Elizabeth Abbott, Project Director, Health Access, September 19, 2006 public hearing, pp. 54-58.		I'm the Project Director for Health Access, which is a statewide healthcare consumer advocacy coalition of over 200 organization, and we offer comments in support of your regulatory efforts. And I'd like to make a few comments to you, probably of a considerably less technical nature than previous testifiers. I will probably not be talking about market driven and product lines. I'm probably going to be mentioning things like beneficiaries and consumers, which I think also is the responsibility of the Insurance Commissioner's office to in fact consider. Page 55 We in fact see that the Commissioner's job is to protect consumers. Patients are not actuaries. And they often don't have a complex and sophisticated knowledge of the marketplace, what various policies can and in fact will deliver. They don't have information or the ability to assess whether or not the product is providing appropriate value for the premium dollar. And that's why it's important that those things be taken into account by the Commissioner of Insurance. We think that some plans actually do lack value in the current marketplace. We find that often, and we have quite a network of beneficiaries and other organizations that help and deal with beneficiaries, so we're basing it based on	The Commissioner agrees.

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		the information that we receive on real life consumers. We find that what are so-called skeleton plans often provide limited coverage with very high deductibles. And often available to meet the key purposes of health insurance, which are to allow patients to get the care they need to live healthier lives and to safeguard their family against financial complications as a result of health insurance failures. We think the loss ratio isn't actually not a bad proxy for the value of a policy. And it is in fact one key or criteria as to whether sufficient percentage of the premium dollar goes to patient care as opposed to Page 56 administrative profit or other operational expenses. I don't know if you are amused by it, but I was sort of struck by the comments about how difficult it is for insurance companies to work in a regulatory environment that has both the Department of Managed Healthcare and the Department of Insurance. I think it's -- there has been a tendency among some product lines, shall we say, to form shop or to find themselves a mechanism to be regulated by the Department of Insurance, because you are perceived to be somewhat easier as a regulatory oversight body than the Department of Managed Healthcare. That's probably not entirely fair, because some of the rules under which you are operating have existed for a long time and you are now attempting to bring those into the 21st century, to make them more stringent and operating according to circumstances that exist in 2006 and beyond. We urge you to do that, and I think after 40 years it's probably time to change the standard and to adjust it upward. We support your proposal to raise the loss ratio to 70 percent, but would suggest that you need to go farther. I have a comparison for you that you may want to consider as a sort of counter point to some of the testimony you've already heard. Page 57 Prior to joining Health Access I was original	

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		administrator for the Centers for Medicare and Medicaid Services in San Francisco. And I had responsibility for regulating those programs at the federal level, Medicare and Medicaid, in the states of California, Arizona, Nevada, Hawaii the Far Pacific. Medicare achieves a administrative cost percentage of about one-and-a-half percent a year, which is interesting when Medicare is being touted as a model for many health insurance reforms. Medicare for all, et cetera, on the national forum, and in some state forums as well. I think that it is not possible for the administrative expenses for the Medicare program to be buried because they are not taken from the Medicare Trust Fund, they are appropriated yearly by congress, and they are watched very carefully. And I think the dedicated people, both employees and -- federal employees and contract employees, do an excellent job of delivering high quality product at very low administrative cost. Now some of you would argue that it is a little unfair to compare a government program with a marketplace program. But I would also point out that the Centers for Medicare and Medicaid Services is a very small agency, 4,600 nationally, and the way that we Page 58 achieve such remarkably low administrative expenses is we contract much of that claims work and customer service and auditing and all those kinds of things in the insurance industry out to contractors. And among those contractors are some of the people that you have interaction with, Blue Cross, Aetna, Blue Shield, are all Medicare, were at one time, and in many cases still are, Medicare contractors. So I urge you to consider your regulations and not be deterred by the probably genuine, but concerns about marketplace concerns, and to keep uppermost in your mind the difficulties that consumers have in getting healthcare insurance in the present day and age. That's all I have to say.	

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Topic 10: Role of Agents			
L3, C3.p.19 Steven Lindsay, CAHU		Specific Issues In item one of the "Description of the Public Problem" the Commissioner presents the thesis that the individual purchasers lack the expertise to judge the level of benefit and lack any market power to find a product that fits their needs. In addition to the insult for individual purchasers, the Commissioner provides no evidence, let alone creditable evidence, to document the foundations for this thesis. It would seem redundant and to a large degree obvious that state law prohibits anybody from transacting insurances unless the Department has licensed them as an insurance agent and those agents do have as indicated by their license the expertise and market power to help the individual negotiate the insurance coverage that fits their needs and budget.	The Commissioner respectfully rejects this comment; the Commissioner acknowledges and respects the important role that insurance agents play in the individual health insurance market. The Updated Informational Digest has been changed to reflect this, and to correct any misunderstanding. However, the recent experience of individuals in the market clearly indicates that, even with the assistance of an agent, individual purchasers lack the market power and expertise of large employers purchasing group products. Also, individuals are faced with medical underwriting, which does not confront group purchasers.
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 16		As the Commissioner defines the problem, consumers have no purchasing power or no market clout and no expertise. However, the Department does license insurance agents, and we do have market power and we do have expertise. And since you effectively say in order to transact insurance you have to do it through a licensed agent, I'm at a loss to understand how the Commissioner could make those assertions when he, in effect, licenses us to have those duties, to employ and provide those duties to the folks that we serve, to our clients. The Commissioner was accurate in the sense that small group products tend to have better medical loss ratios	The Commissioner respectfully rejects this comment; the Commissioner acknowledges and respects the important role that insurance agents play in the individual health insurance market. The Updated Informational Digest has been changed to reflect this, and to correct any misunderstanding. However, the recent experience of individuals in the market clearly indicates that, even with the assistance of an agent, individual purchasers lack the market power and expertise of large employers purchasing group

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		than individual products. However, I think there were some problems with his assertions about the reason for that. Small group insurance in California has guaranteed issue, and we tend to see richer benefits. 0017 And we tend to see the costs spread over wider populations. And those tend to be the reasons, I think, for the fact that they have better medical loss ratios. The cost to administer small group product is significantly less than the cost to administer an individual product. I won't have to send out an individual bill to everybody as opposed to sending one bill for 20 people to somebody, I have a significant administrative savings. There is a significant administrative savings when folks in the workplace can help somebody understand their benefits. Whereas when you have an individual consumer you don't have that. They either have to pick the phone up and call their agent or call their carrier. And the list just goes on and on and on and on in terms of the differences in the actual cost to put that kind of a product on the marketplace. that we've headed for products that have higher deductibles and co-pays, and that the service level from what I'm hearing from my members has actually gone up as we've headed to those products, people have more questions about what's covered, what's not covered, what applied to their deductible, what didn't apply to their deductible. And so we have smaller premiums and p.18 smaller, if you are talking about a fixed percentage, which makes it harder to provide that same service level, than if you have a 50 percent loss ratio as opposed to a 70 percent loss ratio. Now in the end where we firmly believe that most of the products that are successful in the marketplace will hit a 70 percent loss ratio, the ones that are actually selling that they move enough product on will hit it. But you have product, and I know the Commissioner has chosen to highlight a Blue Cross product called TONK. For a number of	products. Also, individuals are faced with medical underwriting, which does not confront group purchasers. Notwithstanding the administrative savings inherent in group insurance, the Commissioner is confident that the participants in the individual insurance market will still be able to provide their policyholders with excellent service while still providing reasonable benefits in accordance with the proposed amended regulation. Further, as regards the testimony regarding products achieving a 70 percent loss ratio, the use of a lifetime anticipated loss ratio takes into account low loss ratios in the early years of a policy form's life cycle.

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		different reasons that product may or may not hit the 70 percent loss ratios. I do not know if they'll, in the end, be able to move enough of that product to get there. But the products that sell in the marketplace will get there. It may take them two years or five years, but they will get to that 70 percent loss ratio when they have enough market share. It's the innovative products in-between that may not get there. And so we're afraid of constricting the innovation.	
L5, C4, p. 27 Leanne Ripperger, PacifiCare		Finally, there is one other potential unintended consequence of this regulation we would like to point out. There are a wide variety of individual health insurance distribution channels that help create multiple points of market access for consumers. These distribution channels provide service, particularly in the form of education for consumers. Some existing distribution channels may be too expensive for carriers to support under the loss ratio requirements of this proposed regulation. This will particularly affect individuals that choose to seek the advice of an independent insurance professional.	The Commissioner respectfully rejects this comment, as the funds available for the distribution channels for individual policies have increased the rate of medical inflation, while the cost of distribution itself has only increased at the lower rate of general inflation. Further, the fact that Medicare supplement policies, which by statute have a higher loss ratio than the 50% loss ratio currently applicable to individual policies, are nonetheless able to fund a abundant distribution system, rich with information, and fully capable of supporting the service and advice of insurance professionals, demonstrates that raising loss ratio requirements is not incompatible with distribution and service.
L6,C1, p. 28 David Dellinger, NAIFA-Calif. ↓		While NAIFA-California appreciates the Commissioner's efforts to address concerns in the health insurance marketplace, for the reasons set forth below, NAIFA-California objects to the Proposed Regulation on grounds that the standards set forth in Government Code § 11349.1 (authority, clarity, consistency, necessity) cannot be satisfied. Consequently, the Proposed Regulation should not be adopted without revision.	The Commissioner respectfully rejects this comment; the Commissioner acknowledges and respects the important role that insurance agents play in the individual health insurance market. The Updated Informational Digest has been changed to reflect this, and to correct any misunderstanding. However, the recent experience of individuals in the market clearly

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		First, the pretext of these regulations is based on a number of policy statements with which NAIFA-California is in disagreement. The policy statement in totality completely neglects the role of the agent in the individual marketplace and as an integral link between the consumer and insurer. Agents, more than any other player in the insurance industry, have a direct stake in protecting the consumer. Agents assist consumers to determine their specific insurance needs and help them select the appropriate policy (or policies) that meet their needs within their budget. Additionally, they serve as educators and a resource to consumers regarding insurance benefits and help consumers resolve any problems with the insurance company about collection of benefits. This not only helps to empower consumers, but ensures that whether they are in a group, small group, or individual market that their needs are met.	indicates that, even with the assistance of an agent, individual purchasers lack the market power and expertise of large employers purchasing group products. Also, individuals are faced with medical underwriting, which does not confront group purchasers.
↓		NAIFA-California agents working in California are well aware of the current state of our healthcare system. With the continued escalation of costs adding economic pressure to employers and individuals making the uninsured situation worse, proper steps need to be taken to reverse the trend. However, an increase of 20% to the minimum loss ratio will ultimately drive up the cost of health plans, completely ignores the fact that many of the individual market products are intended to lower cost, and may ultimately result in a loss of consumer choice.	The Commissioner respectfully rejects this comment, because, as the loss ratio is, by definition, a ratio between benefits and premiums, an increase in the loss ratio cannot result in a concomitant increase in premiums, as the policy in question would then fall out of compliance with the loss ratio standard.

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↓		NAIFA-California abides by the principle that the true concept of health insurance is protection from severe financial hardship, not coverage for every medical occurrence. This being said, we believe that all Californians should have access to a very basic, affordable health care policy. Such an increase in the loss ratio would create a competitive disadvantage to HMOs, ultimately taking a basic, affordable option away from those consumers who may need and desire it most.	The Commissioner respectfully rejects this comment, because, while the different statutory structures behind managed care and insurance products makes comparisons of limited utility, nonetheless it is not evident why an increase in loss ratios for insurance products would act as a competitive disadvantage for managed care products.
Topic 11: Preliminary Screening Procedure			
L7, C8, p. 33-34 JP Wieske The Council for Affordable Health Insurance		s2222.13 Preliminary Screening Procedure This section provides for an investigation of the creditability of the company experience based on a nation-wide survey. We feel, wherever the data allows, that California should allow companies to use creditable California experience rather than relying exclusively on national data.	The Commissioner respectfully rejects this comment, as it is no longer relevant. The proposed amendment completely repeals the section discussed, existing 2222.13. Further, the amended section 2222.14 provides that the Commissioner may consider credibility factors consistent with sound actuarial practice.
Topic 12: Other Letters			
L11, p.49 Henry Garman		I am writing to discuss the proposed loss ratio regulatory change for California. As a small roofing business owner, I very much believe in free enterprise and competition. If I owned an insurance company, I would most definitely refrain from doing business in this state; it is way too restrictive.	The Commissioner agrees that changes in health care over the past 40 years has raised particular challenges regarding availability and affordability of health insurance. For this reason, ensuring that policyholders obtain reasonable value for their premium dollars has

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		When I was growing up, the state had very little control over the insurance/provider relationship. Almost everybody who needed medical attention received it – doctors even made house calls! Now, demand outstrips supply. If the state feels that medical costs are too high, they should experiment and shoulder the costs with a state-sponsored medical program. Then, it might be realized that too much state control is not the most effective way of achieving affordable goals. When President Kennedy came into office, he reduced taxes by 10%; yet President Johnson and his successors raised taxes. I am not convinced that we have seen any improvement in public services. I appreciate you're taking public comment and strongly hope that you will take my opinion into consideration.	become even more important. As regards the commenter's suggestion regarding assessing the experience with state-sponsored medical programs, the Commissioner observes that decades of experience with the Medicare and MediCal programs have shown that such programs can be run with lower administrative costs than is seen with private health insurance, even when such government programs are operated through a private insurer.
L12, p.50 Pearl Regis		As a life long California resident who is currently uninsured, I am writing to express my concern about the intention of the California Department of Insurance to raise the percentage that insurance providers are required to pay in benefits. As mentioned, I am currently uninsured, which means that I pay all of my medical expenses with my savings. I have been lucky enough so far to avoid any major health crises, but I have been looking into getting insurance just in case. Unfortunately, I am afraid that the potential changes the Department of Insurance is discussing will only make paying for insurance more	The Commissioner shares this commenter's concern regarding the cost and availability of health insurance. The increase in medical insurance premiums has been driven by the steep rate of medical inflation. Requiring a higher loss ratio means that a larger part of each premium dollar is available to pay these increased costs: thus, the Department anticipates that a higher loss ratio will moderate the increase in health insurance premiums. With higher loss ratios required in a competitive market, the Department anticipates that competition among insurance companies will

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		costly. If insurance providers are forced to pay more in benefits, they will have to compensate in other ways. That will probably mean that premiums will go up, and I would think that the quality and comprehensiveness of many plans will be compromised. If the goal of the state is to help people like me to get insurance, this does not seem like a good way to do so. In fact, I would expect that people, who are just barely able to afford coverage, may have no choice but to cancel their plans if there is a spike in the cost of insurance. As I start to look into health coverage, I want to have as many options as possible so I can find the most affordable, high-quality plant available, and with the proposed revision, this will undermine my efforts as an individual. Thank you for your due consideration.	encourage efficiency regarding administrative costs, and that supporting the market with a reasonable loss ratio requirement will support the availability of a wide range of insurance options.
L13. p.51 Barbara Pratt		I wanted to express my opinion on the California Department of Insurance's plan to increase the amount that insurance providers pay out in benefits. As the Volunteer Director of a local museum and the Director of the Boron Chamber of Commerce, I am a very active member of my community. I consider myself lucky to have health coverage through the AARP and Medicare, and even luckier because I have never suffered a serious illness or medical complication. Having said all of that, I am writing because I am concerned about the many Californians who may not have quality health care and those who are in poor health. Too drastic an increase in the amount that insurance providers pay out to clients will leave them with far less to cover their expenses. I fear that this will	The Commissioner acknowledges this commenter's concerns. However, the mandate of Insurance Code section 10293 requires that the Commissioner ensure that individual health policy purchasers obtain reasonable value in benefits. By enacting this statute, the Legislature created a mechanism whereby policyholders can be assured of receiving adequate benefits, so that they can obtain the quality health care to which Ms. Pratt refers. The Commissioner has determined that a higher loss ratio, in the current environment, will satisfy the mandate of the statute, while the competitive environment in California will encourage administrative efficiency, rather than leading insurers to leave the market.

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		force many providers to leave the market. Those which remain will probably have to cut back on benefits of increase their premiums, which will make it that much harder for the uninsured to afford coverage. I would hate to see any obstacles arise that will make it more difficult for people to purchase health insurance, especially when there are already so many who cannot afford it.	
L 14, p. 52 Tammy Scurlock		I am the manager of Works Accent Sheet metal in Long Beach. I'm writing to request that the California Department of Insurance thoroughly review raising the loss-ratio for individual insurance providers. It is imperative that careful analysis is completed before any radical regulatory changes are adopted. All of our metal workers are classified as independent contractors; therefore each must insure him or herself on their own. In this dangerous industry, every metal worker must be insured in order to work here as a vender. Due to the dangerous nature of our industry workers premiums are very high. I fear my workers premiums might increase as a result of raising the loss-ratio percent. Doing this could put the California insurance industry out of balance, and force smaller companies to leave California. I ask you to please think carefully about how this policy could affect our metal workers when you meet on the nineteenth. The goal should be to keep people insured.	The Commissioner respectfully rejects this comment, because an increase in loss ratios will not result in an increase in premium, since benefit level and premium amounts are tied together within the ratio. Instead, an increase in the loss ratio will generate increased benefits for consumers, and encourage administrative efficiency.

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L15, p. 53 Tapio Juhola		For over 35 years, I have run my own business, manufacturing small machine parts in Whittier. One of the biggest challenges I have come across has been finding affordable, high-quality health insurance for my employees. I currently have one full-time employee who is covered through the plan I provide and another who will be eligible after he completes 90 days of work. One thing I've learned is that the more policies and providers that are available, the easier it is to select a plan. I wanted to write because I learned that the California Department of Insurance is considering a new regulation to raise the amount that individual policies pay back out in benefits. If the increase is too large, it would be of no surprise if policies suddenly became more expensive, as companies will have to make up the difference somehow to continue operating efficiently. The other likely option is that providers will just close up and leave the market. With fewer options and higher prices, it will be harder for businesses like mine to continue offering insurance as a benefit to employees. The only people this policy will benefit are those who don't mind limited options and more expensive plans and I'll be surprised if there's anybody out there like that. If a change is going to be made, it had better not be one that will reduce competition among providers.	The Commissioner respectfully rejects this comment. The commenter mentions operating efficiency: the market forces behind this efficiency will encourage further innovation, such that insurers will be able to continue to participate actively in the market while providing an increased return of benefits to policyholders. Also, an increase in loss ratios will not result in an increase in premium, since benefit level and premium amounts are tied together within the ratio. Instead, an increase in the loss ratio will generate increased benefits for consumers, and encourage administrative efficiency.

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L 16, p. 54 Mary Nelson		The purpose of my letter is to share my frustration and hope in regard to the status of health insurance in California. I understand the California Department of Insurance is considering a major change to the loss ration percent. I fear this change will adversely affect many individuals who struggle with health issues and the lack of comprehensive insurance. Please heed my story as I am sure it is shared with many other residents in this state. I currently do not have insurance. My employer is not able to provide health insurance because of the cost, and the fact that it is a small company. At one point, I worked with a large company and had a group policy through them. Even at that time the insurance plan we were on was not very comprehensive and was not able to help me with my health problems which consequently got worse and generated secondary issues. I used to be very active with horseback riding and I treasured hiking in our beautiful California surroundings. Because of a spinal and knee injury, I am now unable to enjoy these activities. My previous plan paid for medication to reduce the pain in my knee, but would not cover the knee surgery itself. To my mind, it would have been more cost-effective for them to cover the surgery rather than paying for medication indefinitely. Now, no insurance company will carry me because of these conditions. If I belonged to a large company, they would be required to provide some type of coverage. I cannot seek treatment for my knee, back or consequent weight gain. I am extremely frustrated not	This comment highlights the difficulty consumers have in obtaining available insurance that provides adequate benefit. As insurance becomes increasingly expensive, it is vital that it return enough in benefit that persons like this correspondent can obtain needed care. Inasmuch as this commenter asserts that an increase in individual loss ratios will decrease availability and increase cost, however, the Commissioner respectfully rejects this comment, as the Commissioner believes that these outcomes will not result.

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		only at being cut off from activities I enjoy, but also at not being able to see a doctor to get help. I would sincerely like for you to think of me and my situation when debating new policy regulating the health insurance industry. Without health care, life can be very difficult. My hope is that any new policy will make it easier for individuals, or even small business to obtain affordable and good health care, and this can be ensured by careful study of the drastic loss ration proposal. Thank you.	
L 17 ,p.55 Dawn Klose, California Agriculture Export		I'm writing on behalf of my company, California Agriculture Export. As a small business owner, I am concerned about the recent trend in individual health insurance costs for my employees. It has been brought to my attention that insurance regulatory changes will be discussed in a few weeks so I feel this is the perfect opportunity to voice my concerns. Although my company is not large, I provide insurance to a number of employees. I would actually like to extend health insurance to all my employees, but because of rising costs with insurance policies, I am unable to do so. The higher costs are affecting smaller insurance companies as I have already had to change insurance providers once this year due to a reduction in healthcare options. My concern is that if the loss-ratio is raised to 70 percent, leaving 30 percent to the insurance company, smaller providers will be unable to handle the financial burden and lose out to larger companies, which can	The Commissioner acknowledges this comment, and appreciates the concerns behind it. The Department's experience with the insurance industry, however, leads the Commissioner to conclude that both small and large insurers will be able to operate and compete effectively in an environment in which all market participants are required to provide a more reasonable return of benefits to policyholders.

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		handle increased regulation. This in turn will not only result in fewer insurance choices, but in the long run force the existing insurance companies to raise rates to absorb these new regulations. I would appreciate if you would take a closer look at the state Loss Ratio regulation at hand before the California Department of Insurance makes any rash decisions.	
L18, p. 56 Marilyn Gabriel, Coalinga Chamber of Commerce		As the director of the Coalinga Chamber of Commerce, which has about 160 members, I want to express my concern about a policy change that would raise the payout level of individual insurance providers to 70 percent. Such a steep increase will undoubtedly have negative consequences on the state insurance market. Many businesses provide health insurance for their employees, as it can be a great benefit that attracts high-quality workers. Finding an affordable plan can be challenging for small businesses and the policy change that is currently considered could make it even more challenging. It may not be feasible for some insurance providers to stay in business if they have to cover all their expenses and make a profit from 30 percent of the premium. It seems likely that many companies would simply leave the industry, while those that remain might raise their prices in order to stay in business. Fewer options and higher premiums will be detrimental to small businesses, especially those that may already have a hard time finding affordable healthcare for their employees. I hope that you will consider the potential consequences of this policy before any change is	While cognizant of the serious concerns behind this letter, the Commissioner must nonetheless reject its conclusion. The Department's experience with the insurance industry, leads the Commissioner to conclude that both small and large insurers will be able to operate and compete effectively in an environment in which all market participants are required to provide a more reasonable return of benefits to policyholders.

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		made.	
L 19, p.57 Michael and Susan Farris		I am writing in regard to the upcoming hearing where the state plans to review the proposed 70 percent loss ratio increase of individual policy providers. I would ask that you make a thorough review of this proposed policy before executing any drastic measures. We have owned and operated Quality Cooling since 1985, and we prefer having a choice in insurance companies. Increasing the amount each insurance company pays out to beneficiaries would force many companies out of business and limit our choices. We are not in favor of a policy that would force smaller insurance companies out of California. Please consider how this increase would affect small family businesses like ours. We need to have choices in our insurance system.	While cognizant of the serious concerns behind this letter, the Commissioner must nonetheless reject its conclusion. The Department's experience with the insurance industry leads the Commissioner to conclude that both small and large insurers will be able to operate and compete effectively in an environment in which all market participants are required to provide a more reasonable return of benefits to policyholders.
Multiple commenters: L 20, p. 58, Lee Scheuer; L21, p.59, Glenn		I am writing to express my concerns about the proposed disability policy loss ratio (file#RH-06092236) promulgated by the California Department of Insurance (CDI) last July. I believe that mandating a 70% medical loss ratio on all disability policies is bad public policy.	The Commissioner respectfully rejects this comment, for the following reasons: (1) the proposed regulation is concerned with individual health insurance policies only, not all policies of disability insurance. (2) The comments regarding managed care environments is not relevant here, as the policies in questions are not

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Phillips; L22, p. 60, Terry Lee Ives; L23, p. 61, Simon Chew; L 26, p. 64 Jeff Bell; L27, p. 66, Craig Barton; L28, p. 68, Allan Eckman		Generally, a medical loss ration has a very limited value in managed care environments. Based on the article "Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance," by Professor James Robinson, (*Health Affairs* 1997), medical loss ration is not a reliable source of data and should not be used as an official indicator of quality. A number of direct measures of quality already exist, including (1) consumer satisfaction surveys, (2) regulatory audits, and (3) the National Committee for Quality Assurance standards (NCQA). Additionally, mandating a 70% medical loss ratio provides disincentives to invest in quality of care, disease management, electronic medical records, and timely customer service. The proposed regulation is premised on the assumption that lower medical claims costs and higher administrative costs are always a bad thing. This is not necessarily true. In fact, if done correctly, thoughtful investments in administration should result in better quality of care and lower medical claims costs. Finally, the proposed 70% medical loss ratio mandate does nothing to address health care cost drivers. Health care costs in the private market are being driven up by increased regulation, new technology, upward pressure on hospital and doctors' costs, and the continued under funding of public programs. In sum, I am respectfully requesting that CDI reconsider mandating a 70% medical loss ratio on all individual disability policies for the reasons stated above. Thank	managed care products, (3) The Department has reviewed the referenced article from *Health Affairs*. This article is not pertinent to the issues here, however. The article discusses loss ratios as a measure of quality, and offers other measures, such as surveys and audits. The present regulation, however, is not for the purpose of determining quality. Instead, it is for the purpose of ensuring a reasonable relationship between benefits and premiums, as required by statute. Surveys and audits would not accomplish this statutory requirement. As this purpose differs widely from the subject of the article, the article is not relevant to the analysis of this regulation. Further, by supporting the market at a level currently met by many market participants, a reasonable loss ratio supports a vibrant market with a multiplicity of options, while also maintaining a reasonable return of benefits. While the regulation may not address "health cost drivers," this is not the mandate of the statute. Instead, Insurance Code section 10293 requires that the Commissioner assure a reasonable relationship between benefit and premium. Addressing drivers of health care expenses is outside the province of this regulation.

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		you for giving the public the opportunity to comment.	
L 24, p. 62, Lisa M. Bruner		I am writing to ask the California Department of Insurance to closely examine possible consequences of raising the 'loss ratio' of individual health insurance policies. I am concerned that raising the loss ratio for individual policies could make California an unattractive market for insurance companies working with individuals and small businesses. The already poor climate for insurance companies has affected me on several levels; I work for a small business, and our insurance company just informed us that it is going out of business. As a result, I have been tasked with finding a replacement healthcare plan for our organization. I have been approached by a broker, offering different insurance options; however, I still worry that our choices will be limited. On a more personal level, I recently went through rehabilitation for a pinched nerve in my neck. It was very painful and limited my mobility. Of course working in an office, I had no choice but to seek treatment, as it was a necessity. I couldn't just stay home, and a pinched nerve does not conveniently disappear after a few days. I really don't like to go to the doctor unless I absolutely have to, but when I do need medical treatment, I would like more options. Because of limited choices, the cost of rehabilitation was an out of pocket expense.	This comment highlights the difficulty consumers have in obtaining available insurance that provides adequate benefit. As insurance becomes increasingly expensive, it is vital that it return enough in benefit that persons like this correspondent can obtain needed care. Inasmuch as this commenter asserts that an increase in individual loss ratios will decrease availability and increase cost, however, the Commissioner respectfully rejects this comment, as the Commissioner believes that these outcomes will not result.

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		Choice is very important to me. While I believe there good intentions involved in considering a 30-70 loss ratio, I am one of many people who will be affected by a drastic change in regulations. Thank you.	
L25, p.63 Peter Levin		I am writing in regards to the recent proposal to change the loss ratio for individual insurance companies. I am a strong believer that the free market should decide what the loss ratio should be for insurance companies. It is not in our best interest to regulate these companies in a way that may cause them to refrain from conducting business in out state. As a small business owner, I have 6 employees to whom I provide insurance. I find this to be very expensive and every year I research new companies, but have ended up staying with my current provider, Blue Cross. I feel it's very important that my employees have a choice between HMO and PPO depending on their own personal needs. I am concerned that changing this ratio would cause insurers to leave the market to escape higher operating costs. If this happens there will be even less options for me to choose from, which would inevitably lead to higher prices on the part of the insurance company. Having options is very important to me and I do not want to see those choices taken away. I want this issue to be further investigated. Thank You.	The Department's experience with the insurance industry leads the Commissioner to conclude that both small and large insurers will be able to operate and compete effectively in an environment in which all market participants are required to provide a more reasonable return of benefits to policyholders. As a consequence, The Commissioner respectfully rejects this comment, while recognizing the serious concerns that motivated this correspondent to write.

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Letters Outside Limited Scope of Revised Regulation: On October 25, 2005, notice was given of the availability of a revised text of the proposed amendment. The revision was confined to the following sections: 1) 2222.11: (a) Excluding certain supplemental health policies from the definition of "hospital, medical, or surgical policy; (h)(i) adding definition of "disease management expenses" and "lifetime anticipated disease management ratio.: 2) 2222.12: (a) providing that disease management expenses may be included in determining compliance, (b) clarifying that the minimum loss ratio for existing policies, absent rate revision, remains at 50%, (c)maintaining the existing 50% loss ratio level for certain supplemental health insurance policies; The following portions of letters received at the close of the 15-day comment period for the revised regulation (which closed November 9, 2006) addressed topics outside the scope of the revised regulation.			
L31, C4, p.76 J.P. Wieske, Council for Affordable Health Insurance		**Other comments by this commenter in response to 15-day notice:** This commenter also provided comments that repeated parts of his September 19, 2006 correspondence. The following lists the identical sections: L31,C3 = L7, C1 L31, C4 = L7, C4 L31,C5 = L7, C5 L31, C7 = L7,C7 L31, C10 = L7, C9	The Commissioner respectfully declines to respond to these comments, as they are a repetition of comments made at the conclusion of the 45-day initial comment period, and do not relate to the revised regulation portions that were the subject of the 15-day comment period.
L31, C4, p.75 J.P. Wieske, Council for Affordable Health Insurance		**Comment that is outside the scope of the proposed revision:** (Topic 7: Loss ratio amount) Perhaps just as problematic is the concern the potential impact a high minimum loss ratio will have on appropriate administrative expenses. Health insurers provide a number of services not directly related to disease	The 45-day comment period closed on September 19, 2006. This comment was dated November 8, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		management and the reimbursement of medical claims. For example, many insurers have begun to provide access to nurse health lines – call centers staffed by nurses who help consumers navigate the health system. Companies that offer this service will tell you it not just provides good service, but it also saves lives. Too often, patients ignore serious medical problems, and nurse health lines encourage them to seek necessary care. Other core services could also suffer as carriers seek to limit costs. Many health insurers provide 24-hour service, easy payment by credit card, and other services. As the loss ratio is required to rise, many of these services typical today in the California market may begin to disappear. Unfortunately, it will only be consumers who suffer. Finally, the increased loss ratios will also have a disproportionate impact on low-cost benefit plans. While these benefit plans – like HSA-compatible or other high deductible plans – have many of the same cost drivers, they have a much smaller premium base. As consumers who purchase these plans seek more information, ironically California's high minimum loss ratio may force carriers to provide less information.	
L31, C4, p.77 J.P. Wieske, Council for Affordable Health Insurance		**Comment that is outside the scope of the proposed revision:** (Topic 11: Preliminary Screening. See also L7,C8) s2222.14 Credibility Factors While we believe this section is an improvement, we are concerned that the language is too vague. We would suggest that language in the draft should include	The 45-day comment period closed on September 19, 2006. This comment was dated November 8, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond.

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		examples of appropriate credibility, while still allowing the commissioner discretion in accepting unlisted credibility factors.	
L32, C4, p. 80 (Topic 1) Martin Mitchell, America's Health Insurance Plans		**Comment that is outside the scope of the proposed revision:** The application of a new higher loss ratio requirement to the lifetime experience of an existing policy form is particularly problematic for a policy form for which the bulk of lifetime premiums have already been received. Application of the new standards could preclude any future rate increases for a policy that has met or exceeded all existing reasonableness rules to date – i.e. 50% loss ratio test – even in extreme situations where current benefit expenses exceed current premiums. Again we suggest that any increase in the loss ratio should apply only to future premiums and polices issued after the effective date of the new regulation.	The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond.
L33, p.82 (Topic 1) Armand Feliciano, BC Life & Health		**Comment that is outside the scope of the proposed revision:** After reviewing the proposed regulations, it is our position that some provisions exceed statutory authority. In particular, we are concerned with the retroactive provision specified under § 2222.10 Applicability and § 2222.12 Standards of Reasonability (b). The statutory authority cited by CDI for the proposed regulation is under the Insurance Code Section 10293, which states in part the following: 10293. (a) The commissioner shall, after notice and hearing, withdraw approval of an individual	The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		or mass-marketed policy of disability insurance if after consideration of all relevant factors the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged. The commissioner shall, from time to time as conditions warrant, after notice and hearing, promulgate **such reasonable rules and regulations**, and amendments and additions thereto, as are necessary to establish the standard or standards by which the commissioner shall withdraw approval of any such policy…. Our plain reading of this statute is that the proposed regulations have to be "reasonable." In our view, increasing the existing loss ratio standard from 50% to 70% to all policies sold after July 1, 1962, is unreasonable. Existing policies have been developed and priced based on companies' expectation that the remaining percentage of premium not spent on medical expenses would be available for administrative expenses, commissions, taxes and profits. To retroactively change these policies is unreasonable, and therefore, CDI is exceeding its authority under the statute. Furthermore, nothing in the statute states that CDI has the authority to propose retroactive regulations on medical loss ratio or standards of reasonability. If anything the statute tends to suggest that CDI should act on a prospective basis as stated in subdivision (b) below:	

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		(b) Unless the commissioner specifies otherwise in writing in the withdrawals, or subsequent thereto, grants an extension, any such withdrawal **shall be effective prospectively and not retroactively** on the 91st day following the mailing or delivery of the withdrawal. Additionally, we believe that the proposed regulations violate Article I, Section 10, of the United States Constitution , which states in part "No state shall …, pass any bill of attainder, ex post facto law, or law impairing the obligation of contracts …." The proposed regulation intends to change existing contracts and we believe that increasing the medical loss ratio from 50% to 70% impairs obligations under existing agreements. We also believe that the proposed regulations is unconstitutional under the Fifth Amendment of the United States Constitution, which states in part "No person shall be held to answer for a capital …., nor shall private property be taken for public use without just compensation." We understand that it is CDI's interpretation that the proposed regulations are not retroactive because existing policies are only impacted if there are any rate changes. We respectfully disagree with this interpretation because the end result will be the same and that is to alter existing policies. To comply with these proposed regulations, we suggest that the new medical loss ratio be applied to health products delivered or issued after January 1, 2008 and delete the retroactive provision as drafted below:	

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		§ 2222.10. Applicability This article is adopted pursuant to and in implementation of Section 10293 (a) of the Insurance Code, is applicable to individual disability policies …., that are ~~either (1)~~ delivered or issued for delivery to any person in this State on or after ~~July 1, 2007~~ *January 1, 2008*. ~~or (2) delivered or issued for delivery to any person in this State on or after July 1, 1962 and subject to any rate revision effective on or after July 1, 2007.~~ § 2222.12 Standards of Reasonability (b) Benefits provided by a hospital, medical, or surgical policy delivered or issued for delivery to any person in this State prior to ~~July 1, 2007~~ January 1, 2008, ~~and not subject to any rate revision effective on or after July 1, 2007,~~ shall be deemed to be reasonable in relation to premiums if the lifetime anticipated loss ratio is not less than 50%.	
L34, p.84 Ann Eowan, ACLHIC	2222.10	**Other comments by this commenter in response to 15-day notice:** This commenter also provided comments that repeated parts of her September 19, 2006 correspondence. The following lists the identical sections: L34, C1, p. 24 = L1, C1	The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		L34, C2 = l1, C2	
L34,C3, p.86 (Topic 2) Ann Eowan, ACLHIC	2222.11	**Comment that is outside the scope of the proposed revision:** We would urge further revisions in the regulations to exempt all individual limited benefit policies, as defined. Further, we continue to have concerns that neither the Department or ACLHIC know what types of policies would be covered by the arcane language of the definition that applies to disability insurance contracts that have their "dominant purpose" in providing benefits upon which at least 50 percent of the initial premium is allocated to hospital, medical or surgical benefits. We continue to maintain that the term "health insurance" as defined in Section 106 (b) would subsume any products, including comprehensive and limited benefit policies, that reimburse for hospital, medical or surgical expenses. We continue to seek **clarity** as to what policies would be included in the revised definition. We also seek clarity as to whether the exclusions under Section 106 (b) would apply under the revised definition.	The Commissioner responds to the request for clarification as follows: the exclusions under Insurance Code section 106(b) (1)-(8) apply under the amended definition. The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond..
L35, C2, p. 89 David Dellinger, NAIFA-Calif.	2222.10	**Comment that is outside the scope of the proposed revision:** Additionally, NAIFA-California would argue that the Commissioner does not have the authority to establish retroactive application of the proposed regulations to existing policies. Further, the retroactive application of the proposed regulations would impair both the	The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond.

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		underlying health insurance contract as well as contracts with agents for commission on that contract. The proposed regulations would impose a much higher standard on health insurers and their individual health insurance products, because a 70% loss ratio would apply to each individual policy form, rather than allowing an average percentage across an entire book of business. A loss ratio, by definition, would require all administrative costs, including taxes and profits, to be limited to the amount over 70%. These differences in regulatory requirements could have significant adverse economic impacts and competitive disadvantages.	
L35, C2, p. 89 David Dellinger, NAIFA-Calif	2222.12	**Comment that is outside the scope of the proposed revision:** While NAIFA-California has attempted to limit our comments to the revised text of the proposed regulations, we remain concerned about the objections we included in our prior letter of September 19th that have not been addressed in the revised text. NAIFA-California continues to stand by its principle that the true concept of health insurance is protection from severe financial hardship, not coverage for every medical occurrence. This being said, we believe that all Californians should have access to a very basic, affordable health care policy. Such an increase in the loss ratio would create a competitive disadvantage to HMOs, ultimately taking a basic, affordable option away from those consumers who may need and desire it most. Additionally, the quality of health care does not result only from money spent in providers' offices or in hospitals. The funds spent by insurers on implementing	The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond.

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		programs that provide value to customers, such as the costs of reaching special populations and small businesses through agents with tailored products to meet their needs, are administrative costs that provide immense benefit to California businesses and individuals. Plans and insurers that emphasize management of care, unique programs tailored to such populations, and more customer service opportunities will inevitably have higher administrative costs. Limiting the funding for these administrative services through the proposed increase in the loss ratio may ultimately hinder the use and implementation of programs that provide the greatest benefit and efficiency to insureds.	
L36, C1, p. 91 (Topic 7) James Oatman, Assurant Health	2222.12	**Comment that is outside the scope of the proposed revision:** We would, however, like to reiterate our concern as stated in our September 19th letter with the increase in the minimum loss ratio for individual health insurance policies to 70 percent. Based on our experience and expertise in this market, we believe that the regulation would limit competition in the market, and limit consumer plan choice thus negatively impacting the consumer. In addition, there are two concerns with the regulation that we want to highlight. First, premiums should be reduced by premium taxes when calculating the loss ratio. There are other companies that do not pay premium taxes and if this adjustment is not allowed, some carriers will effectively have a lower loss ratio on the premium retained after premium taxes. The regulation should provide a level playing field and not give some carriers an advantage. Allowing premiums	The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond.

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		to be reduced by premium taxes would be an appropriate way of calculating loss ratio.	
L 36, C1, p. 93 (Topic 1) Peggy Camerino, United American Ins.	2222.10	**Comment that is outside the scope of the proposed revision:** 1. We continue to be concerned with the applicability section of the proposed regulation. §2222.10 applies the new loss ratio standard to all policies – including those regulated under the previous version of the rule. Once again we strongly urge you to reconsider and amend any loss ratio proposal to be applied only on a prospective basis. An increase to the lifetime loss ratio on in-force policies will negatively affect insurers in this market. In-force policies were written and designed based on a specific loss ratio target. Companies have generally already committed to commissions payable on in-force policies and have set up deferred acquisition costs (DAC) accounts for these policies.	The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond.
↓		**Comment that is outside the scope of the proposed revision:** 2. We commend you for revisions made to §2222.11. We agree that the exclusion of supplemental policies and short-term policies from the 70% loss ratio standard is important. However, we believe further clarification of this section is needed. The definition of "hospital, medical or surgical policy" includes a policy of "health insurance." The definition of "health insurance" in Insurance Code § 106(b) excludes accidental death and accidental death and dismemberment insurance,	

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		hospital indemnity, some specified disease insurance, disability income, and long-term care insurance, among others. This section should be revised to clarify that these types of coverage are also excluded from the definition of "health insurance" for purposes of the increased loss ratio minimum.	
(Topic 7) ↓		**Comment that is outside the scope of the proposed revision:** 3. The *Policy Statement Overview* contained in the *Notice of Proposed Action* of July 21, 2006 provides …the legislative mandate of a reasonable relationship between premium charged and benefits received requires that the loss ratio requirement be raised in order to support the individual hospital, medical or surgical insurance market and ensure that these consumers obtain fair value for their hospital, medical or surgical insurance dollar. We continue to reject the notion that the loss ratio requirement must be raised "in order to support the individual…market." A significant increase in the loss ratio, as required in §2222.12, particularly if applied retroactively does not support the individual hospital, medical or surgical market. Excessively high minimum loss ratios do not realistically account for substantial costs to insurers such as premium taxes, administrative costs, and marketing and acquisitions costs. In fact, excessively high loss ratio minimums stifle the	The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond. Also, this comment is identical to Letter 9, Comment 2.

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		insurance market. Carrier will carefully weigh the viability of remaining in a market where the loss ratio is excessively high. Appropriate loss ratio requirements allow insurers to operate in a competitive market, which provides consumers with real choice and fair value for their insurance dollar. We urge you to consider the NAIC model loss ratio standards, which set the loss ratio based on the product, and are more appropriate to the health insurance market.	
L 37, C1, p. 95 (Topic 7) Anthony Wright, Health Access	2222.12	**Comment that is outside the scope of the proposed revision:** Support Raising the Standards to Achieve Greater Consumer Value We strongly believe it is important that these standards be revised to reflect current levels of protection for consumers. Since the existing standards have been in effect for over 40 years, they are clearly outdated. We believe the Department has taken an appropriate first step in raising the standard to 70%. However, since these are an important measure of the amount of money that must be actually devoted to patient care, we would have preferred that you established an even higher standard. In the policy conversation about health care costs, most of the focus has been centered on shifting more costs to individual patients and families; we think this rule appropriately refocuses the discussion on getting better value for the cost expended by taking a close look at where our premium dollars go,	The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond.

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		and how they are spent **.**	
L38, C2, p.97 Leanne Ripperger, PacificCare		**Comment that is outside the scope of the proposed revision:** We would first recommend that the Department amend section 2222.17 to include a subsection (3) which would read: (3) Reduce the health insurance premiums of a policy form, to bring the form into compliance with this regulation. This would allow a carrier to reduce its health insurance premiums on the policy form to bring the policy form into compliance with the regulation. This would appear to be a reasonable solution that should be offered to carriers with existing products that do not meet the loss ratio standards in the regulation.	The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond.
Topic 13: Comments re: proposed revision: supplemental policies			

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
Limited Scope of Revised Regulation: On October 25, 2005, notice was given of the availability of a revised text of the proposed amendment. The revision was confined to the following sections: 3) 2222.11: (a) Excluding certain supplemental health policies from the definition of "hospital, medical, or surgical policy; (h)(i) adding definition of "disease management expenses" and "lifetime anticipated disease management ratio.: 4) 2222.12: (a) providing that disease management expenses may be included in determining compliance, (b) clarifying that the minimum loss ratio for existing policies, absent rate revision, remains at 50%, (c)maintaining the existing 50% loss ratio level for certain supplemental health insurance policies; 5) 222.19: Replacing obsolete reporting provision with a statement of compliance that includes a list of lifetime anticipated loss and disease management ratios for each form, and a statement by an actuary that the standards of reasonability have been met.			
L30, C1, p. 72 Andrea DeBerry, Blue Shield	2222.11	Section 2222.11 Definitions The recent revisions to the proposed regulations incorporate several exceptions to the term "hospital, medical and surgical policy" including supplemental policies of individual health insurance that provide coverage for vision care expenses only, dental care expenses only, or short-term limited duration health insurance with coverage durations of 6 months or less. This appears to acknowledge that imposing a 70% loss ratio standard on these limited benefit policies would virtually price these products out of the marketplace. Indeed, subsection (c) of Section 2222.12 deems benefits provided under these policies reasonable in relation to the premium if the lifetime anticipated loss ratio is not less than 50%. However, the specific wording of the regulations doesn't allow for other types of supplemental policies that may already exist in the market, or that may be introduced in the market in the future, that would be equally crippled if the 70% loss ratio standard is applied. We believe that the language needs to be more broadly worded in order to accommodate other existing limited	The Commissioner respectfully rejects this comment. The revised definition of 'short-term limited duration health insurance" is consistent with the definition in Insurance Code section 12671(e)(8), which provides, in pertinent part, that "'Short-term limited duration health insurance' means individual health insurance coverage that is offered by a licensed insurance company, intended to be used as transitional or interim coverage to remain in effect for not more than 185 days, that cannot be renewed or otherwise continued for more than one additional period of not more than 185 days, and that is not intended or marketed as health insurance coverage, a health care service plan, or a health maintenance organization subject to guaranteed issuance or guaranteed renewal pursuant to relevant state or federal law."

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		benefit polices and to allow for market innovation of other supplemental or limited benefit health insurance coverage.	
L30, C1, p. 72 Andrea DeBerry, Blue Shield ↓	2222.11	In addition, this same section of the draft regulation applies multiple standards to the same type of policy with regards to short-term limited duration health insurance. Short-term limited duration health insurance plans can be offered up to 12 months.(footnote1) Under the draft regulations, a 6-month policy would be subject to a 50% minimum loss ratio, while a policy issued between 6-12 months would be subject to a 70% minimum loss ratio. This would impose 2 different standards on short-term limited duration health insurance based on the length of coverage – a decision made by the consumer very often during the period of coverage and while already insured under the policy. Short-term health insurance products may be offered for different lengths of time, and may also have an option to extend coverage. For example, one short term health insurance product currently offered in the market is available for up to six months for one premium payment. This same plan has an option to extend coverage up to 365 days (not to exceed 365 days for all coverage combined). Another short-term health insurance product that is offered in the market is available up to 365 days and is paid month-to-month by the consumer. In both situations, the consumer ultimately decides the length of coverage (up to 365 days for both products), and does not always make this decision at the outset of coverage. The consumer currently has a choice for length of coverage, and also chooses how they will pay for that coverage (one lump sum or billed month-to-	(Please see response immediately above.)

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		month). Both products are designed and rated similarly and serve the same purpose. But imposing a 70% minimum loss ratio standard on one option effectively eliminates that choice from the marketplace. Imposing two standards would also impact a 6-month policy if the consumer has the option to extend that coverage beyond the 6-month period. (footnote 1: The federal regulations for the Health Insurance Portability and Accountability Act (HIPAA) under 45 CFR §144.104 acknowledge the unique nature of these products and define "short-term limited duration insurance" as "health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within the 12 months of the date the contract becomes effective.")	
↓	2222.11	For all these reasons, we would ask that the reference to "supplemental policies" be further defined as follows: ". . .but does not include ~~supplemental~~ limited benefit policies of individual health insurance. ~~that provide coverage for vision care expenses only, dental care expenses only, or short-term limited duration health insurance with coverage durations of 6 months or less.~~" "The term "limited benefit policy" as used in this article means an individual policy of health insurance that is not marketed or sold as a substitute for comprehensive hospital or medical expense insurance, a	(Please see response immediately above.)

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		health maintenance organization (HMO) contract, or major medical expense insurance. Such limited benefit policies include, but are not limited to, vision-only, dental-only, short-term limited duration health insurance, Champus-supplement insurance, or hospital indemnity, hospital-only, accident-only, or specified disease disability insurance that does not pay benefits on a fixed benefit, cash payment only basis. For purposes of this article, Medicare supplement insurance shall be subject to Section 2222.12(d) of these regulations."	
L31, C1, p.74 J.P. Wieske, Council for Affordable Health Insurance	2222.11	We commend you for moving this regulation forward in a few key areas. First, the exemption for supplemental policies and short-term policies from the 70% loss ratio standard is extremely important. The prior standard would have robbed consumers from access to these valuable products.	The Commissioner acknowledges this comment in support of the revision, although the Commissioner does not agree that a higher standard would have "robbed" consumers.
L31, C4, p.76 J.P. Wieske, Council for Affordable Health Insurance ↓		S2222.11 Definitions The amended standards for short-term medical and ancillary products like dental and vision has improved the regulation. And yet, the model continues to differ from the NAIC model which recognizes different standards based on the product requirements. In this section the term health insurance is broadly defined to incorporate numerous new products. Typically, rate regulations are applied on a product-by –product basis rather than applying a single standard.	The Commissioner respectfully rejects this comment, because (1) the proposed regulation does not regulate rates, (2) a uniform standard achieves clarity and consistency, and (3) After considering the NAIC recommendations, and considering the practices and experiences of other states, the Commissioner determined that a 70% loss ratio would more accurately describe a reasonable relationship between benefits and premium, given the nature of the California insurance market and the needs of

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		Our recommendation would be to incorporate the NAIC definitions for optionally renewable, conditionally renewable, guaranteed renewable and non-cancellable products into the draft and adjust the loss ratios accordingly.	California consumers, for the reasons set forth in the Initial Statement of Reasons.
L32, C1, p. 78 Martin Mitchell, America's Health Insurance Plans ↓	2222.10	We continue to have concerns about the retroactive application of new, higher loss ratio standard to policies issued prior to July 1, 2007 that are (or could be in the future) in need of a rate increase. This would apply to all policies defined in section 2222.11(a), which includes "mixed-benefit" products containing some cash reimbursement benefits along with hospital, medical, and surgical expense benefits. Any increase in the loss ratio should only apply to future premiums and policies issued after the effective date of the new regulations.	The 45-day comment period closed on September 19, 2006. This comment was dated November 9, 2006, and was outside of the scope of the proposed revision (15-day notice period closed November 9, 2006). The Commissioner respectfully declines to respond, other than to observe that applying the new loss to existing policies at the time of rate increases ensures that the reasonable ratio between benefit and premium required by Insurance Code section 10293 benefits existing, as well as new, policyholders.
↓	2222.11	We continue to suggest that all smaller premium "limited benefit" plans be excluded from this rule. We recognize and appreciate the exclusion, of this revised language, of vision-only, dental-only, and short term policies with a 6 month duration or less. We strongly suggest that other types of smaller premium products also be carved out, including products such as hospital indemnity, hospital-only, accident-only, specified disease, disability insurance, and Champus-supplement insurance.	The definition incorporated into section 2222.11 includes reference to the definition of "Health Insurance" described in Insurance Code section 106(b). Various types of disability insurance, including disability income, hospital indemnity, accident only, and specified disease insurance that pays benefits on a fixed benefit, cash payment only basis are expressly excluded from Insurance Code section 106(b), and therefore are also excluded from the scope of section 2222.11. These policies are therefore not subject to the standards of reasonability established in this section. The Commissioner respectfully rejects the suggestion that CHAMPUS-supplement insurance have less than a 70% minimum loss ratio, because this insurance is

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			an important supplement intended to expand the coverage provided by a comprehensive health policy. Because of this, the Commissioner has determined that the policyholders of CHAMPUS-supplement insurance should enjoy the same minimum loss ratio amount provided to holders of individual health insurance policies.
L32, C2, p. 79 Martin Mitchell, America's Health Insurance Plans	2222.11	The second paragraph of the definition of "hospital, medical or surgical policy" raises concerns because a policy that initially does not meet the definition of a hospital, medical, or surgical policy (and thus is subject to a lower loss ratio standard) over time could meet the definition. [This could happen, for example, for a policy that contained medical expense benefits valued at 40% of the premium, and cash-reimbursement benefits constituting 60% of the premium, *when initially file*. Over time the cash-reimbursement benefits will remain the same while the medical expense benefits will increase in value with the medical trend. At some future time, the medical expense benefits will equal and then exceed 50% of the value of benefits under the policy, thus making it qualify under the second paragraph of subsection 11(a) as a hospital, medical or surgical policy. Such a change in status would result, upon a renewal premium filing, in the application of a higher loss ratio standard to all past experience.] With the higher loss ratio requirement applied retroactively, expenses for which a company had a a reasonable expectation of recovery from rates previously approved by the Department may no longer be recoverable. If this occurs, then a company could face unanticipated losses that could result in higher future premiums for consumers. AHIP suggest that the second paragraph	The Commissioner respectfully rejects this comment. The paragraph referred (regarding the "dominant purpose" of a policy) to has been in the regulation since 1962, and has not been changed by this regulation. This regulation provides needed protection to consumers by ensuring that policies which provide substantial health benefits comply with the requirements of Insurance Code section 10293.

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		be omitted from the definition.	
L34, C2, p.86 Ann Eowan, ACLHIC	2222.11	ACLHIC also pointed out in our September 19th letter that there are limited benefit policies that are not meant to substitute for comprehensive insurance that would be included in the definition. Such limited benefit policies would not be able to meet the 70% loss ratio because of their smaller premiums. ACLHIC had provided a definition of "limited benefit policy" and had asked for an exemption for limited benefit policies. The regulations, as revised, make allowances for some types of limited benefit policies, but not all. We appreciate the revisions that allow for a 50% loss ratio standard for vision-only, dental-only and up to six month short-term limited duration health insurance. However, these are not the only limited benefit policies available on the market. Other types of limited benefit policies were included in our proposed definition. That definition is as follows: *The term "limited benefit policy" as used in this article means an individual policy of health insurance that is not marketed or sold as a substitute for comprehensive hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.* ***Such limited benefit policies include, but are not limited to, vision-only, dental-only, short-term limited duration health insurance, Champus-supplement insurance, or hospital indemnity, hospital-only,***	The Commissioner respectfully rejects this comment. The Commissioner has made the determination that, while the supplemental policies listed in the revised regulation have presented a convincing argument for remaining at their current minimum loss ratio requirement, the argument for the other policy types discussed in the comment are less convincing, as they approach more closely the type of policy for which a 70% loss ratio is unequivocally required. For example, the Commissioner respectfully rejects the suggestion that CHAMPUS-supplement insurance have less than a 70% minimum loss ratio, because this insurance is an important supplement intended to expand the coverage provided by a comprehensive health policy. Because of this, the Commissioner has determined that the policyholders of CHAMPUS-supplement insurance should enjoy the same minimum loss ratio amount provided to holders of individual health insurance policies.

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		accident-only, or specified disease disability insurance that does not pay benefits on a fixed benefit, cash payment only basis. *For purposes of this article, Medicare supplement insurance shall be subject to Section 2222.12 (b) of these regulations.* Please note that these products would not be included in the exemptions under Section 106 (b) of the Insurance Code because they are not "cash only" policies, but reimburse for hospital, medical or surgical benefits. Thus, these other limited benefit policies would be effectively taken off the market by the application of a 70% loss ratio to those products. Also, the regulations only exempt short-term limited duration health insurance of up to six months. Many such policies allow for coverage up to one year. By only exempting short-term coverage of a six month term, the regulations would effectively take similar products off the market and remove that consumer choice. Please note that the definition suggested by ACLHIC makes it clear that no product could "get around" the regulations by attempting to market as a limited benefit policy because of the caveat that these products cannot be sold as a substitute for comprehensive coverage, as currently required by the Department when approving these products.	
L34, C5, p.88 Ann Eowan, ACLHIC	2222.12	New Loss Ratio Standards Lack Authority / Consistency. We reiterate our objections that the loss ratio requirements are retroactively applied to existing policies (see comments under "Applicability"). In addition, we note that the revised language incorporates a new loss ratio standard applied solely to vision only, dental only and	(Please see response immediately above.)

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		short-term limited duration health insurance. As our comments under the "definitions" section make clear, there are other types of limited benefit, low-premium policies that would be excluded under this 50% loss ratio requirement, thus effectively taking those products off the market. Again, we would urge the department to apply these lower loss ratio standards to all limited benefit policies.	
L35, C1, p. 89, David Dellinger NAIFA-Calif.	2222.11	NAIFA-California appreciates the revisions to the proposed rulemaking to specify three supplemental policies that are not subject to the increased loss ratio standard. However, the amendments fail to include other supplemental and limited benefit policies that NAIFA-California believes should be excluded from the increased loss ratio standard. Many limited and supplemental benefit policies are very low premium. Imposing a 70% loss ratio standard would price many of these products out of the market entirely in California, thus leaving Californians with less of a choice in the current market.	The Commissioner respectfully rejects this comment. The Commissioner has made the determination that, while the supplemental policies listed in the revised regulation have presented a convincing argument for remaining at their current minimum loss ratio requirement, the argument for the other policy types discussed in the comment are less convincing, as they approach more closely the type of policy for which a 70% loss ratio is unequivocally required. For example, the Commissioner respectfully rejects the suggestion that CHAMPUS-supplement insurance have less than a 70% minimum loss ratio, because this insurance is an important supplement intended to expand the coverage provided by a comprehensive health policy. Because of this, the Commissioner has determined that the policyholders of CHAMPUS-supplement insurance should enjoy the same minimum loss ratio amount provided to holders of individual health insurance policies.

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L36, C3, p. 92 James Oatman, Assurant Health	2222.11	Finally, we would recommend that the definition of a "short-term limited duration health insurance" follow and be consistent with section 12671(e)(8) of the California Statutes.	The Commissioner accepts this comment. The revised definition of 'short-term limited duration health insurance" is consistent with the definition in Insurance Code section 12671(e)(8), which provides, in pertinent part, that "'Short-term limited duration health insurance' means individual health insurance coverage that is offered by a licensed insurance company, intended to be used as transitional or interim coverage to remain in effect for not more than 185 days, that cannot be renewed or otherwise continued for more than one additional period of not more than 185 days, and that is not intended or marketed as health insurance coverage, a health care service plan, or a health maintenance organization subject to guaranteed issuance or guaranteed renewal pursuant to relevant state or federal law."
L 38, C1, p. 97 Leanne Ripperger, PacificCare		We would like to commend the Department for eliminating from consideration of the 70% loss ratio standard, supplemental health insurance coverage, including dental, vision and short-term health insurance policies of six months duration or less.	The Commissioner accepts this comment.
Topic 14: Comments re: proposed revision: disease management (§§ 2222.11(h)(i), 2222.12(a))			
Limited Scope of Revised Regulation: On October 25, 2005, notice was given of the availability of a revised text of the proposed amendment. The revision was confined to the following sections: 6) 2222.11: (a) Excluding certain supplemental health policies from the definition of "hospital, medical, or surgical policy; (h)(i) adding definition of "disease management expenses" and "lifetime anticipated disease management ratio.:			

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7) 2222.12: (a) providing that disease management expenses may be included in determining compliance, (b) clarifying that the minimum loss ratio for existing policies, absent rate revision, remains at 50%, (c)maintaining the existing 50% loss ratio level for certain supplemental health insurance policies; 8) 222.19: Replacing obsolete reporting provision with a statement of compliance that includes a list of lifetime anticipated loss and disease management ratios for each form, and a statement by an actuary that the standards of reasonability have been met.			
L31, C8, p.76 J.P. Wieske, Council for Affordable Health Insurance		s2222.12 Standards of Reasonability This section applies the newly proposed 70% loss ratio to all individual health insurance products. We have issues both with the proposed 70% loss ratio itself, as well as the application of this provision. While it is easy to assume a 70% loss ratio is appropriate, the truth of the matter is that the number is too high. Appropriate loss ratios ensure solvency, provide resources to properly manage a carrier, and in fact can actually lead to lower health insurance premiums. For example, attached is a recent CAHI study, Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector by Merrill Matthews, demonstrates that consumers receive good value for the money spent on administrative costs in the private sector. We would urge you to consider the NAIC approach listed above.	The Commissioner respectfully rejects this suggestion. The NAIC model was considered, but the Commissioner concluded that it included costs that more appropriately should be incorporated into the administrative costs of the insurers, as these costs are not "benefits provided under the policy" within the meaning of Insurance Code section 10293, as the results of these administrative expenditures do not accrue directly to the benefit of the insured. Considering the statutory objective of section 10293, the Commissioner determined that disease management expenses, which generate results that accrue directly to the insured, appropriately may be considered to be a "benefit," but that the other expenses listed in SSAT 85 may not. The Commissioner respectfully rejects this comment The Department has reviewed the referenced CAHI study. While there are certainly administrative differences between Medicare and private insurance, the fact remains that many of the administrative functions shared in common between the two systems, Medicare nonetheless achieves greater administrative efficiency, even when other factors are taken into consideration. In this regard, please see the testimony

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			of Ms. Elizabeth Abbott at page 55 of the transcript of the September 19, 2006 hearing in this matter (this testimony is set forth verbatim in this summary of comments.) In her testimony, Ms. Abbott, a former administrator for the Centers for Medicare and Medicaid Services in San Francisco, stated that "the way that *[Medicare]* achieved such remarkably low administrative expenses is we contract much of that claims work and customer service and auditing and all those kinds of things in the insurance industry out to contractors. And among those contractors are some of the people that you have interaction with, Blue Cross, Aetna, Blue Shield, are all Medicare, were at one time, and in many cases still are, Medicare contractors." This is evidence for the proposition that the private insurance industry can achieve administrative efficiencies similar to those obtained in the Medicare program. After considering the NAIC recommendations, and considering the practices and experiences of other states, the Commissioner determined that a 70% loss ratio would more accurately describe a reasonable relationship between benefits and premium, given the nature of the California insurance market and the needs of California consumers, for the reasons set forth in the Initial Statement of Reasons. Thus, the Commissioner respectfully rejects the suggestion offered by the commenter.

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↓		We do compliment the Department for improving the Standards of Reasonability in this section by including "disease management expenses" in the loss ratio, since these are claim-related and a portion of "losses." Now the Department should take the corresponding step to include other obvious claim-related items as "losses": • *cost containment measures* to hold down provider payments, • *assessments* for risk pool excess claims, • *fraud prevention* costs (payments for fraud are included), • good *grievance procedures*, and • other *claim-handling* expenses.	The Commissioner respectfully rejects this comment. Disease management services, as described, can improve the health of insured, and can therefore reduce claims, and therefore the overall cost of health care. Because of these benefits, the Commissioner has determined that disease management expenses may be calculated as part of the determination of reasonability. However, the Commissioner has also determined that the other expenses listed by the commenter are more appropriately considered administrative expenses, as including them in as benefits in the loss ratio equation would defeat the purpose required by Insurance Code section 10293, which is to assure reasonable benefits are actually provided to the insured. (Continued in next cell, immediately below.)
↓		While these are generally not large relative to provider payments, they are obvious items of the claim process and should be included in the "loss ratio." Note that these costs are already in the loss ratio elsewhere – see the attached Minnesota definition of loss ratio. We also strongly object to requiring the minimum standards for the lifetime of a policy as well as the future lifetime, since a random statistical good year (low loss ratio) means an offsetting future high loss ratio. The relationship of premiums and claims becomes disjointed and artificial. The standard of reasonability ought to apply only to the future anticipated loss ratio. While this may be more difficult to enforce, this one-part loss ratio standard is more appropriate.	(Continued from cell above.) The Department has considered the Minnesota report. In Minnesota, insurance companies, health service plans, and health maintenance organization all operate under the same regulatory framework as regards loss ratios as a regulatory method. This is not the case in California. For the reasons set forth immediately above, the Commissioner has determined that the Minnesota definition of loss ratio would be inconsistent with the benefit requirement of Insurance Code section 10293. Further, the Commissioner has determined that the lifetime anticipated loss ratio is the most accurate

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			method of determining compliance with the standard of reasonability, as past experience provides a means to validate future assumptions. Further, the actuarial method used to develop a lifetime anticipated loss ratio takes random statistical variation into account.
L32, C3, p. 79 Martin Mitchell, America's Health Insurance Plans	2222.11 (h)	The proposed definition of "disease management expenses" differs from but is similar to the National Association of Insurance Commissioners (NAIC) definition of "cost containment expenses." (see below.) AHIP recommend that the Department use the NAIC definition of cost containment expenses, rather than the proposed definition of disease management expenses, so that regulators could use data reported in the Annual Statements to determine the amount of these expenses. This proposal would be less costly for both the state and industry than adoption of a different definition unique to California. The NAIC's definition of Cost Containment Expenses, found in SSAT 85, is: (4)a. Cost containment expenses: Expenses that actually serve to reduce the number of health services provided or the cost of such services. The following are examples of items that shall be considered "cost containment expenses" only if they result in reduced levels of costs or services: i. Case management activities; ii. Utilization review; iii. Detection and prevention of payment for fraudulent requests for reimbursement; iv. Network access fees to Preferred Provider Organizations and other network-based health plans (including prescription drug networks), and allocated	The Commissioner respectfully rejects this suggestion. The NAIC model was considered, but the Commissioner concluded that it included costs that more appropriately should be incorporated into the administrative costs of the insurers, as these costs are not "benefits provided under the policy" within the meaning of Insurance Code section 10293, as the results of these administrative expenditures do not accrue to the benefit of the insured. Considering the statutory objective of section 10293, the Commissioner determined that disease management expenses, which generate results that accrue directly to the insured, appropriately may be considered to be a "benefit," but that the other expenses listed in SSAT 85 may not. Section 2222.12 and 2222.19 provides that the use, and therefore the reporting, of disease management expenses by an insurer is at the insurer's option. If the insurer does not wish to use these expenses in demonstrating compliance with the standard of reasonability, it need not do so.

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		internal salaries and related costs associated with network development and/or provider contracting; v. Consumer education solely relating to health improvement and relying on the direct involvement of health personnel (this would include smoking cessation and disease management programs, and other programs that involve hands on medical education); and vi. Expenses for internal and external appeals processes.	
L32, C4, p. 80 Martin Mitchell, America's Health Insurance Plans	2222.11 (i)	The definition of "lifetime anticipated disease management ratio," raises concerns because the manner in which anticipated claims (the numerator) increase will likely not be the same as the manner in which premiums (the denominator) increase. Projecting future premium increases (i.e. future medical trend) is inherently difficult and highly uncertain. AHIP suggest that the rules allow for the use of the most current ratio of disease management (or cost containment) expenses to premiums for future periods.	The Commissioner respectfully rejects this suggestion. As with lifetime anticipated loss ratios, the use of a lifetime anticipated disease management ratio incorporates both past experience and future projections. The use of past experience serves as a check on the accuracy of the future projections, and therefore provides more accurate information regarding the compliance of the policy with the standards of reasonability.
L34, C4, p.87 Ann Eowan, ACLHIC	2222.11	Definition of "Disease Management Expense" and "Lifetime Anticipated Disease Management Ratio" Lack Clarity / Consistency. In our September 19th comment letter, ACLHIC had requested clarity as to what expenses were included in the definition of "lifetime anticipated loss ratio" as added by the proposed regulations. The Department has included only one type of administrative expense in the revisions, namely, those costs associated with disease management programs. While we appreciate this one change, we would point out that the Department is using definitions that are inconsistent with the National Association of Insurance Commissioners' (NAIC) definition of cost containment expenses, as	The Commissioner respectfully rejects this suggestion. The NAIC model was considered, but the Commissioner concluded that it included costs that more appropriately should be incorporated into the administrative costs of the insurers, as these costs are not "benefits provided under the policy" within the meaning of Insurance Code section 10293, as the results of these administrative expenditures do not accrue directly to the benefit of the insured. Considering the statutory objective of section 10293, the Commissioner determined that disease management expenses, which generate results that

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		reported by companies on their Annual Statements. Thus, the regulations will require companies to use separate, and more costly methods, to determine the appropriate allocation of expenses. We would ask that the revised regulations be further amended to utilize the NAIC definition, in order to allow companies to utilize their existing reporting in the Annual Statements. There are sufficient similarities between the NAIC definition and the revised definition in these regulations as to meet the goal of the department. The NAIC definition (as defined in the Annual Statement Instructions) is as follows: "Claim adjustment expenses, including legal expenses, can be subdivided into cost containment expenses and other claim adjustment expenses: a. Cost containment expenses: Expenses that actually serve to reduce the number of health services provided or the cost of such services. The following are examples of items that shall be considered "cost containment expenses" only if they result in reduced levels of costs or services: i. Case management activities; ii. Utilization review; iii. Detection and prevention of payment for fraudulent requests for reimbursement; iv. Network access fees to Preferred Provider Organizations and other network-based health plans (including prescription drug networks), and allocated internal salaries and	accrue directly to the insured, appropriately may be considered to be a "benefit," but that the other expenses listed in SSAT 85 may not.

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		related costs associated with network development and/or provider contracting; v. Consumer education solely relating to health improvement and relying on the direct involvement of health personnel (this would include smoking cessation and disease management programs, and other programs that involve hands on medical education); and vi. Expenses for internal and external appeals processes."	
L36, C2, p. 92 James Oatman, Assurant Health	2222.11	Second, adjustments for disease management should be expanded to include large case management and other interventions that improve the claim costs incurred on behalf of the customer. Insurance carriers should be provided with an incentive to improve members' health and lower claim costs. We would also again recommend a sliding scale loss ratio standard as follows: ➢ 60% for market share 5% or less ➢ 65% for market share 6-10% ➢ 70% for market share 11% or greater;	The Commissioner respectfully rejects this comment. The Commissioner has determined that the other expenses listed by the commenter are more appropriately considered administrative expenses, as including them in as benefits in the loss ratio equation would defeat the purpose required by Insurance Code section 10293, which is to assure reasonable benefits are actually provided to the insured. Further, competitive pressures will provide incentives for insurers to undertake the interventions described. The Commissioner had considered the commenter's market-share sliding-scale approach, and respectfully rejects it. The Commissioner has determined that a single, set minimum loss ratios would have the advantage of clarity, certainty, and consistency, while the market-share approach would be uncertain, and based on data that would be hard to predict on a going-forward basis.

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L 37, C1, p. 95 (Topic 7) Anthony Wright, Health Access	2222.12	<u>Lesser Standards for Specialty Plans as a Transitional Step</u> We recognize that while vision, dental, and short-term limited duration health insurance companies argued for relief from the Department's new standards, we urge you to consider the lesser 50% standard for that portion of the industry to be an interim requirement. We believe that since specialty care also has a significant impact on quality of care and health outcomes, those insurers should be expected to meet the same industry standard of 70% or more after a relatively brief transition period.	The Commissioner acknowledges this comment, but respectfully rejects it as premature at this time. Whether the 50% standard for specialty plans is an interim step is a question best deferred until after the proposed regulation is implemented, and experience data is obtained.
L38,C2, p. 97 Leanne Ripperger, PacificCare	2222.12	We would also like to offer our support for the Department's decision to include a lifetime anticipated disease management ratio in the 70% loss ratio standard. While those changes will ensure that plans and insurance processes that hold down health insurance premiums in a way that is beneficial to the consumer will continue to be offered in the state of California, we do believe that two additional changes should be incorporated into the regulation.	The Commissioner accepts the comment regarding the 70% loss ratio. The response to the commenter's two additional changes appear elsewhere in this Final Statement of Reasons (Topic 12, Topic 15).
Topic 15: Comments re: proposed revision: Statement of Compliance (§ 2222.19)			

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Limited Scope of Revised Regulation: On October 25, 2005, notice was given of the availability of a revised text of the proposed amendment. The revision was confined to the following sections: 9) 2222.11: (a) Excluding certain supplemental health policies from the definition of "hospital, medical, or surgical policy; (h)(i) adding definition of "disease management expenses" and "lifetime anticipated disease management ratio.: 10) 2222.12: (a) providing that disease management expenses may be included in determining compliance, (b) clarifying that the minimum loss ratio for existing policies, absent rate revision, remains at 50%, (c)maintaining the existing 50% loss ratio level for certain supplemental health insurance policies; 11) 222.19: Replacing obsolete reporting provision with a statement of compliance that includes a list of lifetime anticipated loss and disease management ratios for each form, and a statement by an actuary that the standards of reasonability have been met.			
L31, C1, p.74 J.P. Wieske, Council for Affordable Health Insurance	2222.19	We also commend you for a number of important clarifications in the rule. In prior versions of the rule, it was unclear how managed care expenses would be calculated, this rule clarifies that issue. The rule also changes the filing of experience data to a less regulatory burdensome "statement of compliance." This sort of statement better reflects the approaches used by many states who regulate insurance rates.	The Commissioner notes the acknowledgement of the benefits of the proposed revision. The Commissioner notes, however, that the proposed "statement of compliance" includes a requirement that loss ratios be reported. The Commissioner also notes that this regulation addresses the relationship between premiums and benefits, and does not involve rate regulation.
L31, C11, p.77 J.P. Wieske, Council for Affordable Health Insurance	2222.19	S2222.19 Statement of Compliance We appreciate the regulatory flexibility contained in this section. The actuarial certification has been used favorably by many states, and is much easier to file and understand. **It would be desirable for the certification to apply to *rating blocks* of forms rather than *each* form, taking into consideration the credibility of these blocks.**	The Commissioner respectfully rejects this suggestion, because the Commissioner has determined that the level of information specified in section 2222.19 is necessary to ensure adequate compliance with the requirements of Insurance Code section 10293.
L32, C6, p. 81 Martin Mitchell, America's Health	2222.19	We suggest that Section 2222.19 should reference all of the sections 2222.10-2222.14 as the basis for the standards of reasonability, rather than section 2222.12 alone. As noted in our comment on section 2222.11(h), if the	The Commissioner respectfully rejects this suggestion. The reference to section 2222.12 in section 2222.19 is only for the purpose of identifying those policies which must provide a statement of compliance.

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Insurance Plans		definition were changed to the NAIC's term, there no longer would be a need for a "schedule detailing disease management expenses." Finally we suggest that an April 1 submission of a statement of compliance would be unnecessary for policy forms that have been filed and approved in the previous calendar year. Exempting such policy forms from this requirement would provide administrative savings to both the state and insurance carriers.	The Commissioner has determined that, for the reasons set forth above under "Topic14", a detailed report of disease management expenses will provide the best means of determining compliance with 2222.12, for those insurers who choose to use these expenses in their calculations. As discussed above, the other expenses in the NAIC model do not deliver direct benefit to the insured. The Commissioner has considered the suggestion that a statement of compliance not be provided for the calendar year after a policy's approval. The Commissioner respectfully rejects this suggestion because of a determination that a report including the first year's performance will improve regulatory compliance.
L34, C6, p.88 Ann Eowan, ACLHIC	2222.19	**New Statement of Compliance Lacks Clarity.** Section 2222.19 has been revised to require a statement by a qualified actuary that the standards of reasonability have been met for each form (whether open or closed) for the preceding calendar year. Considering the many applicable forms, credibility, and variance of actual loss ratios on a bell curve, we imagine insurers may have several specific forms that do not meet a fixed loss ratio test. Also, rating is often considered for a block of similar forms, and the standards of reasonability ought to apply to that grouping of forms; in particular, note the rules for a closed block in § 10176.10. Therefore, we recommend that **a qualified company official state that, considering credibility of experience, applicable policy forms or rating blocks**	The Commissioner respectfully rejects this comment, because Insurance Code section 10293 provides, in pertinent part, that the Commissioner may "withdraw approval…of an individual..policy" if "the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged." *[emphasis added.]* Further, the Commissioner's remedy if the ratio of benefits to premiums is unreasonable is to withdraw the policy Thus, the Commissioner has determined that it would be inconsistent with the intent of Insurance Code section 10293, which seeks to ensure that each consumer will obtain the advantages of a reasonable relationship between premiums and benefits, for compliance with the standards of reasonability to be

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		of forms are anticipated to meet the standards of reasonability at the end of the preceding calendar year, with any exceptions noted.	reported in rating blocks, or other aggregates or averages of multiple policy forms, as such reporting would obscure those forms for which the policyholders were not receiving reasonable value. The Commissioner has thus determined that, to effectuate the statutory intent, the information must be provided on a per-form basis.
L38,C3, p. 98 Leanne Ripperger, Pacificare	2222.19	Finally, we would recommend that the Department consider implementing a deemer provision which would allow a health insurance carrier to certify that they have met the loss ratio standard in this regulation. This will streamline the regulatory filing process without eliminating the consumer protections included within this regulation.	The Commissioner respectfully rejects this suggestion. As understood by the Department, a "deemer" provision is one in which a filing is deemed approved within a specified time period unless the Department objects. The Commissioner rejects this suggestion because requiring only a certification would not provide the benefits of also obtaining the loss ratio data specified in the proposed regulation. This data will enable the Department to monitor compliance, and track the effectiveness of the amended regulation.
L39 Melanie Lazicki		My husband and I own a flower shop in Artesia. It is a small business, just the two of us. Because it is a small business, affordable health care is an important issue for us, so I am concerned about proposed changes to the state loss ratio percent. The California Department of Insurance is considering changing regulations for individual insurance policies, and I would like to say that I fear it will bring higher rates and less choice in insurance companies working with small businesses. I am worried that if money is redirected away from the insurance companies by such a big number, going from 50% to 30%, it will discourage companies either from	This letter was received on September 27, 2006, after the public comment period closed on September 19, 2006, and the Commissioner respectfully declines to respond.

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		working with us small business owners or at the very least will decrease the number of plans available to us. Please look at proposed regulatory changes as they might bring higher rates and less choice for small businesses. Thank you.	
L40 Daland(?)		This letter is identical to the letter discussed above in Topic 10 under the heading "Multiple Commenters."	This letter was received on October 2, 2006, after the public comment period closed on September 19, 2006, and the Commissioner respectfully declines to respond.
L41 Name illegible		This letter is identical to the letter discussed above in Topic 10 under the heading "Multiple Commenters."	This letter was received after September 28, 2006, after the public comment period closed on September 19, 2006, and the Commissioner respectfully declines to respond.

[1] "Health Insurance in California: Where Do Your Premium Dollars Go?" PowerPoint presentation by Department of Insurance staff at June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236), page 7.

[2] "Health Insurance in California: Where Do Your Premium Dollars Go?" PowerPoint presentation by Department of Insurance staff at June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236), page 8.

[3] California Department of Insurance June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236)., RT 93:8-22, 101:2-105:8.

[4] Survey of Loss Ratio Requirements in Other States for Individual Health Insurance Policies, July 22, 2006, prepared by Department of Insurance Staff.

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